Memorial Blood Centers
737 Pelham Blvd., St. Paul, MN 55114

Suspected Transfusion Transmitted Disease Report

MBC Case # ______________

Name of Institution Reporting: ______________________________ Date __________

Name of Individual Completing Form: ______________________________

Recipient's Name ______________________________ Date of Birth __________

Recipient's Medical Record or Social Security number ______________________________

Primary Diagnosis at time of transfusion ______________________________

Hospital where recipient transfused ______________________________

Suspected Transfusion Associated Infection ______________________________

Status: ☐ Recovered ☐ Convalescing ☐ Acute Illness ☐ Deceased

Date range of transfusion ______________ Date of onset of clinical symptoms ______________

Clinical history ______________________________

Recipient Testing Results:

Date	HBsAg	Anti-HBs	Anti-HBc	Anti-HCV	HCV RIBA	HCV PCR	HIV PCR	Anti-HIV	HIV Western Blot/IFA	Other

Recipient Liver Function Test Results:

Date	ALT	AST	Bilirubin	Other

Other laboratory or clinical data supporting transfusion transmission? ______________________________

Any other possible recipient risk factors other than transfusion? (Describe) ______________________________

Suspected Transfusion Transmitted Disease Report (cont.)

Components Transfused

Date	Unit Number	Compo-nent	Date	Unit Number	Compo-nent

Please use a separate sheet if more than 30 components

Has recipient received any other blood products such as albumin or coagulation factor concentrates? (Please list)____

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Mail to:

Memorial Blood Centers
Donor Medical Services
737 Pelham Blvd.
St. Paul, MN 55114-1739
651-332-7287
FAX 651-332-7001