Nebraska Community Blood Bank
A Division of Innovative Blood Resources

TTD_____

Suspected Transfusion Transmitted Disease Report

Name of Institution Reporting _____ Date _____

Name of Individual Completing Form _____

Recipient's Name _____ Date of Birth _____

Recipient's Medical Record or Hospital ID 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) _____

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Suspected Transfusion Transmitted Disease Report (cont.)

Components Transfused:
List components from NCBB first, followed by components not from NCBB.

Date	Donor Identification Number	Compo-nent	Date	Donor Identification Number	Compo-nent

Please use a separate sheet if more components than spaces.

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

_____

Return to: **NCBB Physician Services**
Fax: 402 486-9429