Recipient Complications – Infectious Disease Case Report

INSTRUCTIONS:
For a transfusion reaction that is suspected to be the result of transfusion transmitted infection, complete this form and send it, along with any supporting documentation*, to the appropriate blood supplier.

For units collected or provided by the Red Cross, send the form to the Donor and Client Support Center (DCSC) using the fax or email information provided below. For questions or to consult with a Red Cross physician, please call the phone number below.

If the reaction resulted in a fatality, then also **report the fatality to the FDA as soon as possible**.

Timely reporting is vital to prevent the possible transfusion of other products collected from the same donor or donors.

**Supporting documentation may include copies of the following:*

- *The form used and completed in the internal hospital work-up*
- *Physician notes regarding the reaction, including admission and discharge information, as applicable.*

DCSC contact information	fax #: 1-888-719-3535	phone #: 1-866-236-3276
	email: VFaxForDCSC@redcross.org	

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Reporting Health Care Facility Information

Name	
Address:	
Report date:	

Section I: Clinical Information

Recipient/Patient Information:

Recipient ID (patient #):		Age or DOB:	Gender: ☐ Female ☐ Male
Primary diagnoses:			
Attending physician:			
Phone:		Email:	
Transfusion service medical director:			
Phone:		Email:	
Contact for additional information:			
Phone:		Email:	

Patient status (at time of report)

☐ Living, asymptomatic from infection	☐ Living, symptomatic from infection	☐ Deceased, unrelated to transfusion
☐ Deceased, related to possible transfusion transmitted infection	Date and time of death:	
	Will autopsy be performed?	☐ No ☐ Yes

Infection that may have been transfusion-acquired

☐ Hepatitis A	☐ Hepatitis, non-A, B, or C	☐ Babesiosis	☐ Malaria
☐ Hepatitis B	☐ HIV	☐ Chagas disease	☐ West Nile Virus
☐ Hepatitis C	☐ HTLV	☐ Other (specify):	

First indication of infection

Date symptoms first presented, diagnosis, or of testing:	
☐ Clinical disease, mild/moderate	☐ Clinical disease, severe

☐ Positive infectious disease test result

State why recipient was tested for this disease:

☐ Other abnormal laboratory tests (specify):

☐ Other (specify):

FOR RED CROSS USE ONLY	Case ID number:	
	Date report received:	

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Section I: Clinical Information (continued)

List ALL test results pertinent to infection, including confirmatory testing if performed.

HEPATITIS CASES

Test		Pre-transfusion (results and date)	Post-transfusion (results and date)
Bili total (normal range: ____ to ____)			
Bili conjugated (normal range: ____ to ____)			
AST/SGOT (normal range: ____ to ____)			
ALT/SGPT (normal range: ____ to ____)			
Alk phos (normal range: ____ to ___)			
HBsAg and/or HBsAg neutralization			
Anti-HBc			
HBV by PCR (or comparable)			
Other (Please specify):			
Vaccinated for hepatitis B?		☐ No ☐ Yes*	
* If yes, last vaccination dose received on (date):			
Anti-HAV total			
Anti-HAV IgM			
Anti-HCV by EIA			
Anti-HCV by RIBA			
HCV by PCR (or comparable)			
Other hepatitis tests (specify)			

HIV CASES

Test	Pre-transfusion (results and date)	Post-transfusion (results and date)
Anti-HIV by EIA		
Anti-HIV by Western Blot		
HIV by PCR (or comparable)		
Other HIV tests (specify)		

OTHER INFECTIONS

Test	Test method used	Pre-transfusion (results and date)	Post-transfusion (results and date)
Babesia			
WNV			
Other (identify):			

Please indicate why confirmatory tests, if applicable, were not performed:

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Section I: Clinical Information (continued)

Risk factors: Mark any risk factors that were present prior to the first evidence of infection	
☐ Patient has no known risk factors	☐ Patient could not be assessed for risk factors.

☐ Drug use (injected drugs not prescribed by a physician)
☐ Sexual behavior (payment for sex, partners with risk factor)
☐ Sexual partner with past or current history of infection with HIV or hepatitis
☐ Rape/sexual assault victim (unknown HIV/hepatitis status)
☐ Lived with individual with hepatitis
☐ Received transplant (for example, organ, tissue, bone marrow) or tissue graft (for example, bone or skin)
☐ Accidental needle stick or contact with someone else's blood
☐ Tattoo (in what state?): _____ (Regulated facility?): _____
☐ Piercing (with unsterile needles?): _____
☐ Juvenile detention/lockup/jail or prison >72 consecutive hours or residence in halfway house/ group home
☐ Dialysis
☐ Pooled factor concentrates for bleeding disorder
☐ Transfusions before 1990 (date of transfusion): _____
☐ Travel to pertinent risk area for reported infection (risk area): _____
☐ Resided in endemic country for reported infection (country): _____
☐ If disease is congenitally spread, mother resided in risk area during prenatal period
☐ Other known risk factors for reported infection: _____

Did this patient receive products from other blood suppliers? ☐No ☐ Yes
(If yes, separate notification of suppliers may be required)

Please describe any other significant clinical details of the case not yet provided:

Rank the likelihood that this infection was transfusion-acquired based on the initial clinical impression (check one):				
☐ Highly probable	☐ Likely	☐ Possible	☐ Cannot exclude	☐ Unlikely

Transfusion Service Medical Director Name (print):	
Signature/Date:	

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Case ID number:

Section II: Transfusion History

Total number of Red Cross products you are reporting: _____
(If the total number of products exceeds the lines available, use additional copies of this page to record).

Red Cross-Supplied Blood Products

For Transfusion Service Use		
Unit number	**Product name or code****	**Transfusion date/time**

**Needed as multiple co-components from the same unit number may have been shipped to your facility; providing the container number is also acceptable.