Community Blood Bank of Erie County
2646 Peach St. Erie, PA 16508

REPORT OF TRANSFUSION TRANSMITTED DISEASE (TTD)

(Attach Additional Pages if Necessary)

Date_____ Hospital:_____

Patient: _____Hospital ID #_____

SUSPECTED TTD: Hepatitis B _____ Hepatitis C _____ Bacteremia _____ TRALI _____

HIV-1 _____ HTLV I _____ Chagas _____ Zika _____

Babesiosis _____ WNV _____ SYPHILIS _____

Other: _____

Blood Products Transfused within previous 6 months:

	Unit ISBT # (complete number)	PRODUCT CODE	Date Of TX
1			
2			
3			
4			
5			
6			
7			
8			

Clinical and Laboratory Data Supporting Diagnosis:

	Date	Test	Result
1			
2			
3			

Date Diagnosis Established: _____ **Date of Death (if applicable):** _____

Title and name of person completing this form: _____

Return Completed form to:

QA Department
Community Blood Bank
2646 Peach St.
Erie, PA 16508-1895

REV: 4.20 (Registry of Adverse Reactions to Transfusions)