

REPORT OF SUSPECTED POST TRANSFUSION DISEASE (PTD) PATIENT MEDICAL INFORMATION

Patient		Birth date	
Address		Gender	
		Race	
		Occupation	
Date Disease Suspected		Date Reported to CBC	
Attending Physician		Contact Person	

Symptoms/Physical Findings (check applicable)	Final Diagnosis:
<input type="checkbox"/> malaise <input type="checkbox"/> abdominal pain <input type="checkbox"/> fever <input type="checkbox"/> anorexia <input type="checkbox"/> splenomegaly <input type="checkbox"/> nausea <input type="checkbox"/> rash <input type="checkbox"/> hepatomegaly <input type="checkbox"/> vomiting <input type="checkbox"/> arthralgias <input type="checkbox"/> hepatic tenderness <input type="checkbox"/> jaundice: date of appearance _____	
Suspicion of PTD based on: _____	
Patient sample available? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Laboratory Results								
Assay	Reactive	Negative	Confirm. Test *	Date	Assay	Range	Result	Date
HBsAg					Bilirubin Total			
Anti-HBc					Bilirubin Direct			
IgM anti-HBc					AST (SGOT)			
Anti-HBs					ALT (SGPT)			
IgM Anti-HAV					Alkaline Phosphatase			
Anti-HCV					PT			
Anti-HIV					PTT			
Other					Biopsy Diagnosis			

*Confirmatory test results are critical to the PTD investigation.

OVER

Transfusion History (attach additional, sheet if necessary)			
Attending Dr. at the time of transfusion:		Diagnosis at time of transfusion:	
Transfused with units from CBC?	Yes No	Transfused with units from other facility?	Yes No
Unit ID Number	Date Transfused	Unit ID Number	Date Transfused

Key: Unk = Unknown

Product	Circle answer	Date
Other blood derivative?	No Yes Unk Specify _____	
Factor concentrates?	No Yes Unk Specify _____	
Immune Globulin (IG)?	No Yes Unk	
Hep B immune globulin?	No Yes Unk	
Hepatitis B vaccine?	No Yes Unk	

During the six months prior to onset of illness, was the patient...	
1. Sexually active? 2. Multiple partners? Gender of partners?	1. No Yes Unk 2. No Yes Unk 3. M F Both
In contact with confirmed or suspected hepatitis case?	No Yes Unk Type: _____
Employed in medical or dental field?	No Yes Unk
Attended by dentist or oral surgeon?	No Yes Unk
1. Known to have ear/body piercing? 2. Tattoo? 3. Acupuncture?	1. No Yes Unk 2. No Yes Unk 3. M F Both
Known (or suspected) to self-administer illegal drugs by injection?	No Yes Unk
An international traveler?	No Yes Unk
Known to take...1. Alcohol? 2. Acetaminophen?	1. No Yes Unk 2. No Yes Unk
Other hepatotoxic drugs?	No Yes Unk
List medications:	

Completed by:		Date:		Telephone:	
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Please return to: Manager, Donor Testing Laboratory, Community Blood Center, 4040 Main Street, Kansas City, MO 64111