NATF 2104 01

(Relates to SOP No. NATS MED 013)

POSSIBLE TRANSFUSION/TRANSPLANTATION TRANSMITTED INFECTION

This form should be completed by the referring clinical team in liaison with SNBTS consultant.

PATIENT DETAILS		
SURNAME:		**HOSPITAL:**
FORENAME:		**CHI NO:**
ADDRESS:		**Treating Clinician:**
SEX:	**DOB:**	
CLINICAL DETAILS:		
DETAILS OF SUSPECTED TTI:		
DATE OF DIAGNOSIS:		
RATIONALE FOR POSSIBLE TTI: Please give a brief timeline of events, including when the patient was transfused, other treatments received (e.g. allogeneic grafts / transplants) and any history of negative test results for the TTI. Have other sources of infection been excluded?		

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TRANSFUSION/TRANSPLANTATION DETAILS: Include component/product types, dates and locations of transfusion/transplantation and donation numbers. **Donation numbers** are required to enable traceback investigation. If a print-out is available from the blood bank or hospital system, donation numbers can be sent separately as a pdf document. Please do not include any identifiable donor information e.g. names from historical legers on this form.

PATIENT TESTING RESULTS:	
Sample Date	**Viral (or other TTI) Markers**

Please forward copies of:

1. Laboratory reports confirming the presence of the infection reported
2. Computer print-out of all transfused blood components (if available)

NAME:	**DATE:**
POSITION:	**HOSPITAL CONTACT FOR THIS CASE:**

PLEASE RETURN COMPLETED FORM TO:

nss.snbtsdcst@nhs.scot for possible TTIs associated with transfusion
Sharon.Zahra@nhs.scot for possible TTIs associated with transplantation
Do not send this report by e-mail unless using a secure network (nhs encryption)