TRANSFUSION-RELATED INFECTION REPORT

In order to insure the safety of the blood supply, all blood products transfusion-related infections must be reported to the Traceback and Notifications department of Héma-Québec. A traceback will be initiated concerning donors associated with the products transfused to the involved patient. I understand that Héma-Québec will initiate such a traceback and will send me conclusions as soon as the traceback is finished. Conclusions will also be sent to my patient.

Infection in question: ☐ Hepatitis B ☐ Hepatitis C ☐ HIV ☐ HTLVI-II ☐ Other (specify) : __

Surname (common name) : ________________________ First name: ______________________

Maiden name (name at birth) :____________________________________ Sex : ☐ F ☐ M ☐ Fr☐ Eng

Address: ____ Postal code : _____________

Birthdate : ________-_____-_____ (dd-mm-yyyy) Tel : ____________________________

Date of death (if applicable): _____-______-______ (dd-mm-yyyy)

External reference number (please specify):____

Has this patient ever given blood? ☐Yes ☐No ☐Unknown If yes, When(year)? __ Where(city)? ____

Diagnostic and tests history

List all tests/diagnostic methods (please enclosed a copy)

Date (dd-mm-yyyy)	Tests (Elisa, Riba, other)	Laboratory (Name)	Résults (Pos, Nég, Indéterminate)	Copy Yes	Copy No
______	______	______	______	☐	☐
______	______	______	______	☐	☐
______	______	______	______	☐	☐

Completed by(signature): ________________________________ Date :____________________(dd-mm-yyyy)

Transfusions history

Hospitals where the patient received or believes to have received transfusions (List all known transfusions)

Hospital	Year of transfusion
______________________	__________________
______________________	__________________
______________________	__________________

Completed by (signature): ________________________________ Date :____________________(dd-mm-yyyy)

Identification of products transfused

Please fill in the form “transfused blood products list” (FRM-00042, FRM-00043) or join a complete list of all the blood donations transfused indicating : Blood group, donation number, products or components and the date of transfusion. Sign and date (the signature of the blood bank director or his designate is required).

Signature : ____ Date :_______________(dd-mm-yyyy)

Réservé à l’usage d’Héma-Québec

Demandé par : ☐DSP ☐CH ☐Médecin ☐Patient ☐Autre : ______________________________ Date : _____________
Numéro d’enquête attribué : ______________________________ Par : __________________ Date : _____________
Poursuivre l’enquête ☐Oui ☐Non (Signature chef) : ______________________________ Date : _____________
Envoyé à : (autre établissement) ____________________________ Par : __________________ Date : _____________
ÉDA ☐S/O ________________________________