

Michigan Blood
P.O. Box 1704, Grand Rapids, MI 49501-1704
Fax #: 616-233-8661

ARE Case: _____ Discrep #: _____
(if applicable)
Date Received: _____ By: _____

ADVERSE RECIPIENT EVENT (ARE) – Infectious Agent

Reporting Facility: _____ Phone: _____

Patient Name: _____ Date of Birth: _____ Male Female

Hospital/Medical Record Number: _____ Reporting Physician: _____

TYPE OF INFECTIOUS AGENT

Record lab results on reverse.

Hepatitis B Virus (HBV)
 Hepatitis C Virus (HCV)
 HIV/AIDS

HTLV
 West Nile Virus (WNV)
 Other: _____

PATIENT INFORMATION – Complete both sides (page 1 and 2)

Diagnosis: _____

Reason for transfusion: _____

Clinical history relevant to adverse event: _____

Other potential reported or observed risk factors:

Explain/date:

- Prior transfusion: _____
- High risk sexual contact: _____
- Drug use: _____
- Occupational exposure: _____
- Dialysis: _____
- Other: _____
- None** (Check here if no other risk factors are known to exist)

Unit(s) implicated in the adverse recipient event: *(Use extra sheet or attach computer printout if available)*

Unit #	Component	Date of Tx	Unit #	Component	Date of Tx

Michigan Blood Comments: _____

Patient Results

	Pre-Transfusion Sample date _____	Post-Transfusion Sample date _____
HEPATITIS:		
Bilirubin		
Liver function tests: _____		
HAV		
HBsAg (confirm)		
HBsAb		
HBcAb Total (IgG & IgM)		
IgM HBcAb		
HBeAg		
HBeAb		
HCV Ab		
HCV RIBA		
HCV RNA (PCR/NAT)		
Other		

HIV:

HIVAb		
HIV-1 RNA (PCR/NAT)		
Western Blot		

HTLV:

HTLV Ab		
Immunoblot / RIPA		

WNV

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Other:
