I. Physician Notification of Autologous Patient Donor Testing

Patient/Donor _____ Date Collected _____

Blood Unit Number _____ Expiration Date _____

Date of Intended Transfusion _____

Doctor _____ Hospital _____

Patient/Donor testing does not meet established requirements for the screening test(s) marked but will be issued for transfusion to the patient/donor.

_____ HIV-1/HIV-2 (IFA positive)

_____ HIV-1/HIV-2 (IFA negative or indeterminate)

_____ Nucleic Acid Test for HCV RNA, HIV-1 RNA, HBV DNA, or ZIKV RNA

_____ Nucleic Acid Test for West Nile Virus

_____ HBsAg (nonconfirmed)

_____ HBsAg (confirmed)

_____ Anti-HTLV-I/II

_____ Anti-T. cruzi (Chagas)

_____ Anti-HBcore

_____ Anti-HCV

_____ STS

Signed _____ Date _____

MEDIC Laboratory

Please acknowledge the receipt of this notification by your office. Reply promptly to MEDIC at Fax # 521-2643. Components will not be issued until MEDIC receives acknowledgment of receipt of this notification.

Signed _____ Date _____

Physician's office