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  _____ Anti-T. cruzi (Chagas)
_____ HBsAg (nonconfirmed)  _____ Anti-HBcore
_____ HBsAg (confirmed) _____ Anti-HCV
_____ Anti-HTLV-I/II  _____ 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

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