BLOOD CENTER OF NORTHCENTRAL WISCONSIN, INC.
211 Forest Street
Wausau, WI 54403

TRANFUSION TRANSMITTED DISEASE/INJURY REPORT FORM

Reporting Facility: ____________________________
Reported By: ____________________________ Date: ____________ Disease/Injury: ____________________________
Transfusion Date: ____________________________

Patient’s Previous Transfusion History: ____________________________
Patient’s Known Risk Factors: ____________________________ Relevant Lab Results: ____________________________

<table>
<thead>
<tr>
<th>Suspect Unit #(#s)</th>
<th>Component Type</th>
<th>(Blood Center Use Only)</th>
<th>Initial &amp; Date</th>
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<td>RBC</td>
<td>FFP</td>
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(Blood Center Use Only)

TTDI Case #: ____________________________
Form Completed By: ____________________________
Medical Director Review: ____________________________
Date Effective: October 1, 2009

BPD #: ____________________________
Date: ____________ Case Closure Date: ____________

Document Control Number: TTDI.f1.v3