APPENDIX D

EXAMPLES OF FORMS AND LOGS FOR NOTIFICATION OF INFECTIOUS DISEASE RESULTS

RECORD OF DONOR NOTIFICATION

CONFIDENTIAL

Donor Name ______________________________ Hospital ID ______________________________

Telephone Numbers (h) ____________________ (w) ______________________________________

*Social Security Number ____________________ *Date of Birth ____________________________

Reason for Donor Notification ____

Notification Letters Sent

Date Letter 1 was Mailed ___________________ Date Letter 2 was Mailed ____________________

Restricted Delivery Receipt Returned to Region? Yes __________ No __________

Letter Returned Marked No Forwarding Address? Yes __________ No __________

Telephone Calls To or From Donor

Date/Time of Contact __________/____________ *ID confirmed? Yes __________ No _________

Date/Time of Contact __________/____________ *ID confirmed? Yes __________ No _________

Comments ____

____

____

Appointments for Personal Interview Donor Notification

Date/Time of Appointment ________/________

If First Appointment Not Kept or Cancelled: Date/Time of Appointment ________/________

Signed Information Release Form Received? Yes _________ No ________ N/A _________

Test Results Mailed to Donor’s Physician? Yes _________ No ________ N/A _________

***Ask the donor at the beginning of each telephone contact to state this information for identify verification.**

INFORMATION RELEASE REQUEST

I authorize *insert Cord Blood Bank name here* to release the results of my blood test for *insert name of blood test here* to me and/or to the following doctor or clinic:

Your name (only if you are requesting that your test results be sent to you)

____

Your address (only if you are requesting that your test results be sent to you)

____

____

Doctor’s Name ____

Name of Facility ____

Street Address ____

City, State, Zip Code ____

Donor/Guardian Signature ____

Donor/Guardian Printed Name ____

Donor Social Security Number ____

Today’s Date ____

Please return this form to: *insert Cord Blood Bank name and address here*

____

CBB Staff Use Only

Hospital ID Number ____

AUTHORIZATION FOR RELEASE OF TEST RESULT INFORMATION

I authorize *insert Cord Blood Bank name here* to release the results of my blood test for *** HIV, anti-HTLV-I/II/anti-HTLV-unable to distinguish viral type* to the doctor or blood center listed below and that I donated blood to that facility on or about *insert date here*.

Doctor's Name ____

Name of Facility ____

Street Address ____

City, State, Zip Code ____

Donor Signature ____

Donor Printed Name ____

Donor Social Security Number ____

Today's Date ____

CBB Staff Use Only

Hospital ID Number ____

Donation Date ____

**** Select appropriate test name.**

DONOR COUNSELING WORKSHEET

CONFIDENTIAL

Date of Counseling ____

Hospital ID Number ____

Place a check mark next to the items that were discussed with the donor:

1. Specific test results requiring notification ____
2. Information from the appropriate fact sheet ____
3. Placental donation that tested positive and was destroyed ____________________________
4. Donor's name and other identifying information has been added to a confidential list of deferred donors ____
5. Donor is no longer eligible to donate blood ____
6. Donor was referred to his/her personal physician for further medical evaluation and followup _
____
7. Written materials were provided ____
8. Local support resources were discussed (if applicable) ____________________________
9. Donor has/has not donated blood since 1977 ______________________________________

   If yes, list locations and dates to the best of the donor's recollection ______________________
   ____

Ask donor to sign an Authorization For Release of Test Result Information Form.

________________________________ ________________________________
Counselor Signature Date

CORD BLOOD TRANSPLANTATION STUDY
NOTIFICATION LOG

Page ___ of ___

Bar Code Label	Type of Letter Mailed	Date Mailed	Comments