

Request for Autologous / Directed Donations

PATIENT INFORMATION		ALL INFO MUST MATCH HOSPITAL RECORDS	Date
Last	First	Middle Initial	
Birth Date	Last 4 Digits of SS# ___ ___ ___ ___	Gender Male <input type="checkbox"/>	
Address		Female <input type="checkbox"/>	
City	State	Zip	
Daytime Phone		Evening Phone	

HOSPITAL INFORMATION - DO NOT ABBREVIATE

Scheduled Date of Usage	Medical Record Number (if applicable)
Patient's Blood Type	Type of Procedure/Diagnosis
Facility Name	City/State

ORDERING PHYSICIAN INFORMATION

Last	First
Address	Phone #
City	Zip
	Fax #

<p><u>AUTOLOGOUS</u></p> <p><input type="checkbox"/> Whole Blood</p> <p><input type="checkbox"/> Red Blood Cells</p> <p><input type="checkbox"/> Plasma</p> <p>Other, please specify:</p> <p><i>By signing below, Physician confirms the patient will be able to tolerate the Autologous blood donation procedure(s) and does not have any medical contraindications for blood donations. Please ensure the risks and benefits of Autologous donations and/or transfusions have been discussed with the patient.</i></p>

<p><u>DIRECTED</u></p> <p><input type="checkbox"/> CMV Negative</p> <p><input type="checkbox"/> Red Blood Cells</p> <p><input type="checkbox"/> Platelets</p> <p><input type="checkbox"/> Plasma</p> <p><input type="checkbox"/> Apheresis Platelets</p> <p>Other, please specify:</p>

Physician's Signature: _____

Date: _____

FAX COMPLETED REQUEST AND AN ADDITIONAL SET OF DEMOGRAPHICS TO 713-791-6607
Please call (713) 791-6608 for questions or to download this form check web site www.giveblood.org.