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 ☐ Female ☐
Address		
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 #

AUTOLOGOUS

☐ Whole Blood
☐ Red Blood Cells
☐ Plasma

Other, please specify:

*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.*

DIRECTED

☐ CMV Negative

☐ Red Blood Cells
☐ Platelets
☐ Plasma

Other, please specify:

Physician's Signature: _____ **Date:** _____

FAX COMPLETED REQUEST AND AN ADDITIONAL SET OF DEMOGRAPHICS TO

713-790-1782 or 832-930-4888

Please call (713) 791-6608 for questions or to download this form check web site **www.giveblood.org**.