Request for Autologous / Directed Donations

Fax completed request and an additional set of demographics to **(346) 547-5699**.
Please call (713) 791-6608 for questions. Download this form at **www.giveblood.org**.

Orders are valid for 2 months.
Referring physician must discuss the desired number of units to be collected with the patient prior to referral.

PATIENT INFORMATION – ALL INFORMATION MUST MATCH HOSPITAL RECORDS

First Name:	Last Name:	MI:
Date of Birth:	Last 4 Digits of SS#: ___ ___ ___ ___	Gender: Male ☐ Female ☐
Address:		
City/State:	ZIP:	Phone #:

HOSPITAL INFORMATION – DO NOT USE ABBREVIATIONS

Date of Usage:	MRN (if applicable):	Patient's Blood Type:
Type of Procedure/Diagnosis:		
Facility Name:		
Address:	City/State:	ZIP:

ORDERING PHYSICIAN INFORMATION – ALL INFORMATION IS REQUIRED

First Name:	Last Name:
Phone #:	Fax #:

PLEASE COORDINATE WITH YOUR INSTITUTION'S BLOOD BANK TO ENSURE AN AUTOLOGOUS/DIRECTED PRODUCT WILL BE ACCEPTED

AUTOLOGOUS

Autologous donors will be able to donate as much as one unit every 5 days.

☐ Whole Blood ☐ Red Blood Cells ☐ Plasma

☐ Will accept units with positive infectious disease testing

Please specify any other processing requests below:

*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
☐ Irradiated
☐ Red Blood Cells
☐ Platelets
☐ Plasma

Please specify any other processing requests below:

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