

REQUEST FOR AUTOLOGOUS DONOR BLOOD COMPONENTS

Physician Instructions										
 Complete <i>every</i> section to avoid communication and processing delays. Submit request by fax <i>at least 3 weeks prior to scheduled surgery or transfusion</i>; autologous donation(s) should be completed at least 2 weeks before surgery. FAX COMPLETED REQUEST TO 909-386-6817. 										
QUESTIONS?		Call LifeStream's Special Services Department: 1-877-386-6874								
Patient Information										
Full Name (LAST, FIRST MI)						Date of Birth				
SSN or MR #						Sex at Birth (CIRCLE ONE)			М	F
ABO-Rh Blood Type (IF KNOWN)						Patient Phone #			_	
Autologous Unit(s) Poguested										
Autologous Unit(s) Requested Packed RBCs QUANTITY: (350mL / not leukoreduced)										
Surgery/Transfusion Information										
Hospital	Facility Address									
Surgery/ Diagnosis			Surgery/ Transfusion Date(s)							
Doguester Information										
Requestor Information Physician Cradeatists										
Name (Print)							Crede	entials		
Direct Phone #			Emai	il			Fax			
Physician's Consent and Request for Autologous Donations										
I understand that the LifeStream Medical Director has the final responsibility for determining donor suitability.										
In my opinion, the patient is physically able to withstand the withdrawal of the ordered components. <u>I am aware that severe anemia, cardiovascular instability or any signs of bacteremia or viremia are contraindications for autologous blood collection.</u> I have discussed autologous blood collection with my patient and in my opinion, the patient understands the nature and risks of the proposed procedure and that autologous donation is an optional alternative to using units from the community blood supply. Authorized Signature/Credentials (MD/DO, NP, PA) Date										