

REQUEST FOR DIRECTED DONOR BLOOD COMPONENTS

Physician Instructions:

- Complete **every** section to avoid communication and processing delays.
- Provide list of ABO-Rh compatible donors; **typically, 1 donor = 1 unit of blood.**
- Obtain signed approval from a transfusion services representative at the patient's transfusing or surgical facility **before** submitting request to LifeStream.
- Submit by fax **no later than 2 weeks prior to scheduled surgery or transfusion.**

FAX COMPLETED REQUEST TO (909)386-6817.

QUESTIONS? Call LifeStream's Special Services Department: 1-877-386-6874.

Recipient Information

Patient's Full Name		Date of Birth	
ABO-Rh Blood Type (REQUIRED)		Sex at Birth (CIRCLE ONE):	M F
MR #		Patient Phone #	
Patient Representative (IF APPLICABLE)		Representative Phone #	

Surgery/Transfusion Information

Hospital		Address	
Surgery / Diagnosis		Surgery/Transfusion Date(s) (REQUIRED)	

Red Cells Requested *(Please list at least one donor per unit requested on next page.)*

Quantity (#) of Packed RBC Units (REQUIRED)		If CPDA-1 RBC's requested, check here: <input type="checkbox"/>
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Requestor Information

Physician Name (Print)		Credentials	
Direct Phone #		Email	Fax

REQUEST FOR DIRECTED DONOR BLOOD COMPONENTS

Directed Donor List

- ✓ LifeStream does not provide *pre-donation* blood typing or CMV testing for donors.
- ✓ Incompatible ABO-Rh donations will be distributed and billed to the ordering facility.
- ✓ LifeStream will contact donor(s) to schedule their donation; please provide contact info.

Directed donations are by appointment only through our Special Services Dept.

Donor's Full Legal Name	Date of Birth	Blood Type	Address	Phone #
1.				
2.				
3.				
4.				

If more than four donors, continue list on a separate page and attach.

A. Ordering Physician's Consent for Directed Donations

I understand that the LifeStream Medical Director has the final responsibility for determining donor suitability. I understand that LifeStream implies no warranty that directed components decrease the generally recognized risks of transfusion reactions, infections, and disease transmission. I have discussed directed blood collection with my patient and in my opinion, the patient understands the nature and risks associated with directed donations which are optional alternatives to using units from the community blood supply. In signing this order, I am agreeing to accept blood from the directed donors listed above and authorized by my patient providing they meet all regulatory and testing criteria.

Print Name: _____ Credentials: _____

Signature: _____ Date: _____

(Ordering MD/DO, NP, or PA)

B. Hospital Transfusion Services Representative Approval

Print Name: _____ Title: _____

Signature: _____ Date: _____

Phone #: _____

Fax completed request to (909)386-6817.

For assistance, contact Special Services at 1-877-386-6874.