LifeStream
GIVE HOPE | GIVE LIFE | GIVE BLOOD

REQUEST FOR DIRECTED DONOR BLOOD COMPONENTS

Schedule Appointment for all donor centers and auto van by **Faxing orders to 909.386.6817 or Call Toll Free – 1.877.386.6874**.
Donor centers are located in San Bernardino, Riverside, Ontario, Victorville, La Quinta, and Murrieta. **IMPORTANT**
PLEASE MAKE SURE PATIENT AND PHYSICIAN SIGNATURES HAVE BEEN OBTAINED PRIOR TO FAXING REQUEST.
DIRECTED DONORS MUST MEET ALL CRITERIA FOR ALLOGENEIC DONORS.

PLEASE PRINT ALL INFORMATION. LEGIBILITY IS REQUIRED!

Recipient:_____ Date of Birth:_____ SSN or MR #:_____
Last Name, First Name, Middle Initial (if used) — MR required for Kaiser pts.

Address:_____ Phone #:_____ : _____
Street Address, Apt. # or Unit # — Home — Work

_____ Phone #:_____
City, State, Zip — Cell

Diagnosis/Surgical Procedure:_____ ABO-Rh Type:_____
Required

Contact Person (Other than Recipient):

Name:_____ Relationship:_____ Phone:_____

Hospital:_____ Surgery/Transfusion Date:_____
Surgery/Transfusion Location

Address:_____ Phone #:_____
(If out of area) Street Address

_____
City, State, Zip

Components Requested	**# of Components Requested**
☐ Packed RBCs	
☐ Packed RBCs + Frozen Plasma	
☐ FP (Frozen Plasma)	
☐ Cryoprecipitate	
☐ Apheresis Platelets (Pre-test Required)	
☐ Octoped (Packed RBC divided into equal aliquots at LifeStream)	
☐ Ped Pack (Packed RBC with satellite bags attached to be divided into aliquots at hospital)	
☐ Other ****(Requires pre-approval of LifeStream Medical Director)**_____	

Physician's Name:_____

Address:_____

Phone:_____ E-Mail:_____ Fax:_____

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Patient's Consent for Directed Donation

I agree to receive donated units from the acceptable donors specified by me and listed below.

I understand the list of acceptable donors must also be approved by my physician.

I understand that it is my responsibility to make certain that the selected donors have a compatible ABO-Rh type for my requirements.

I understand that not all directed donations even those with acceptable ABO-Rh will be compatible with my blood.

I understand that not all donated units will qualify as acceptable units due to abnormal testing results or incompatibility.

I also understand that on rare occasion directed blood is not available because of damage or breakage occurring during processing.

The Directed Donation process and the use of that blood in my care are decisions made by me and my physician and I release LifeStream and its agents from all claims relating to or arising out of either the decision to use blood or blood products provided by LifeStream.

I understand that LifeStream, needs a minimum of 72 hours to test and prepare directed blood and cannot guarantee that it will be available any sooner. LifeStream needs a minimum of 6 days to ship out of area.

I authorize LifeStream and its agents to contact my physician to obtain information necessary for processing the blood donations.

I understand that it is my responsibility to determine if my directed blood donors are the correct blood type. LifeStream will not pre-test my donors and if the blood is not compatible the blood may be used by the hospital for another patient. If I have been required to pre-pay, the cost of the directed fees, this money is not reimbursable to me, in the event the blood is not compatible.

Below is a list of donors authorized by myself and my physician to donate blood for my use.

1. **(PRINT FULL NAME AS APPEARS ON PICTURE ID):**_____
   Donor's Confirmed Blood Type:_____ Donor's Date of Birth:_____
   Donor's Mailing Address:_____
   Donor's Contact Phone Number:_____
2. **(PRINT FULL NAME AS APPEARS ON PICTURE ID):**_____
   Donor's Confirmed Blood Type:_____ Donor's Date of Birth:_____
   Donor's Mailing Address:_____
   Donor's Contact Phone Number:_____
3. **(PRINT FULL NAME AS APPEARS ON PICTURE ID):**_____
   Donor's Confirmed Blood Type:_____ Donor's Date of Birth:_____
   Donor's Mailing Address:_____
   Donor's Contact Phone Number:_____

Patient's Signature:_____ **Date:**_____
(PARENT OR GUARDIAN MUST SIGN IF PATIENT IS A MINOR)

Patient's Name:_____
Print Name

Physician's Consent and Request 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.

_____ _____
Authorized Signature (Ordering MD/DO, NP, PA) Date

Requests with the practitioner's name signed by another individual and initialed or a stamped signature will be returned for an authorized signature.