Autologous Donor Order Form

Ref: 03-01-05

Appointments and Information: (650) 723-6667 FAX: (650) 723-8155

This Form Must Be Completed In Full

Number and Type of Units Requested:		FOR SD DEPT. USE ONLY:
Packed Red Blood Cells		❒ CPD/Adsol
Other:		❒ CPDA-1

Patient Name: _____ Date of Birth: _____
Last First MI

Medical Record Number: _____ Phone: Day: _____ Eve: _____

Type of Procedure Scheduled: _____ Gender: Male ❒ Female ❒

❒Surgery ❒Transfusion Date: _____ ICD-9: _____

Location for Transfusion: ❒ SHC ❒ LPCHS ❒ Other: _____

PHYSICIAN AUTHORIZATION FOR AUTOLOGOUS COLLECTION

Note: Stanford/LPCH Transfusion Service will NOT accept autologous units from patients known to be infected with HIV, HCV, or HBV, or positive on the blood bank testing for the following infectious agents: HIV, HBV, HCV, WNV, HTLV I/II and/or *T. cruzi*.

Blood donation involves an acute loss of 10-15% of the patient's blood volume and may cause transient hypotension. Stanford Blood Center (SBC) requires authorization by a **physician** familiar with the patient's condition prior to performing phlebotomy for patients with the following conditions. Note that the failure to provide authorization at the time of ordering will cause delays in donation.

SBC will make the final decision on donor eligibility at the time of donation. Patients with the following conditions will not be drawn:

- Angina at REST within the past three months
- Requirement for supplemental O_2 except those with secondary polycythemia

I am familiar with the patient's condition and authorize SBC to perform phlebotomy (ies) for autologous blood collection. This patient has a history of the following (check all that apply):

- ❒ Current heart valve disease or congestive heart failure
- ❒ History of angina, MI, stroke, TIA, or heart surgery within the past year
- ❒ Pregnancy currently or within the past six weeks
- ❒ Under 17 years of age
- ❒ Sickle Cell Trait (HgSA)

Physician Name (please print): _____

Physician Signature (Required): _____ **Date:** _____

Physician Phone (Required): _____ **Physician Fax (Required):** _____

Physician Address (Required): _____

FOR BLOOD CENTER USE ONLY	
Collect Prepayment? ❒**Yes** ❒**No (list reason under exception)** **$**	
Exception:	
Comments:	
SD Initials:	Date:
Physician Contact Info. Verified by: _____	Date: _____

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