Directed Donor Order Form

Ref: 03-02-06

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: _____ ICD-Code _____

❒ Surgery ❒ Transfusion Date: _____ Ongoing ❒

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

Patient's Blood Type (**Required):** _____

Please Attach Lab Result of ABO/Rh Typing

Special Requirements:

Is CMV Negative needed? ❒ YES ❒ NO

Note: *If CMV Negative is ordered and donor unit tests CMV positive,* ***unit will not be sent to hospital.*** *If unsure of patient's CMV requirement, please verify with hospital transfusion service* ***BEFORE*** *placing order.*

Physician/NP/PA Name (please print): _____

Physician/NP/PA Signature (Required): _____ **Date:** _____

Physician/NP/PA Phone (Required): _____ **Physician/NP/PA Fax (Required):** _____

Physician/NP/PA Address (Required): _____

FOR BLOOD CENTER USE ONLY	
Comments:	
SD Initials:	Date:
Physician/NP/PA Contact Info. Verified By:	Date: