

Special Collection Order Autologous & Directed

A Patient Information Record					
Last Name	Suffix (Jr.)	First Name	MI	DOB	
Address	City	State	Zip Code	Gender M <input type="checkbox"/> F <input type="checkbox"/>	
Primary Phone	Secondary Phone		E-mail		
Language	ID		ID Type		

B Physician's Order			
Donation Type	Autologous <input type="checkbox"/> Directed <input type="checkbox"/>	Number of Units	Patient Recruited Directed Donor List (provide name) Units from blood relatives will be irradiated unless specified otherwise
Unit Type	Packed Red Blood Cells <input type="checkbox"/>	_____	
	Whole Blood <input type="checkbox"/>	_____	
	Apheresis <input type="checkbox"/>	_____	
	Other <input type="checkbox"/>	_____	
	Other <input type="checkbox"/>	_____	
Test for CMV ▶ Yes <input type="checkbox"/> Leuko-reduce ▶ Yes <input type="checkbox"/> Irradiate ▶ Yes <input type="checkbox"/>			

C Physician's Preassessment of Autologous Donor		Please Check for Past or Present Medical Conditions:
Aortic Stenosis <input type="checkbox"/>	Pulmonary Disease <input type="checkbox"/>	Strokes / TIA <input type="checkbox"/>
Arrhythmia <input type="checkbox"/>	Bacteremia / Infection <input type="checkbox"/>	Seizures <input type="checkbox"/>
Cardiac / Cardiovascular Disease <input type="checkbox"/>	Currently Pregnant <input type="checkbox"/>	
Restriction of Physical Activity/Disability <input type="checkbox"/>	Current Anticoagulant Therapy <input type="checkbox"/>	
Wheelchair <input type="checkbox"/>	Weight: _____ lbs	
Other <input type="checkbox"/>	Cardiologist/Primary Physician Must Complete Section C if Present	
Please list current medications _____		

D Ordering Physician's Information		
Physician Name	Phone:	Fax:
Office Contact	Diagnosis / Surgical Procedure	Transfusion Date
Transfusion Service / Hospital	City	State
Physician Signature:	Date:	

E Medical Clearance To Be Completed by Cardiologist or Primary Physician		
Cardiologist/Primary Physician Name	Phone:	Fax:
Yes <input type="checkbox"/> ▶ It is my medical judgement that the above patient has no contraindications to give his/her own blood for autologous transfusion. The patient may donate at an American Red Cross site without a physician present.		
No <input type="checkbox"/> ▶ It is my medical judgement that the above patient should not donate autologous blood.		
Physician Signature:	Date:	

F For Red Cross Use Only		
Assessment and Evaluation of Section C Indicates Medical Clearance is Required:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Signature: _____
Medical Clearance Received by (Init/ID)	Date: _____	
Sections A, B, and D Verified by (Init/ID)	Date: _____	