vitalant

Center Information:

# Special Collections Request

Please print legibly or type all information requested. Thank you.

Patient Name _____ M F _____
Last First Middle Sex Date of Birth

Patient Address _____
Street City State Zip

Phone Number _____ Weight _____ lb Blood Type (Directed Donation only) _____

Emergency Contact Name _____ Phone _____

Hospital/Customer _____ Hospital Patient # if known _____

Hospital Address _____
Street City State Zip

Date of Surgery/Need _____ Type of Surgery/Diagnosis _____

Patient Information (Autologous Only)

Donors with the following conditions will require approval from the donor's primary physician and the Vitalant Medical Director

| | |
|---|---|
| ▪ Angina in the past 6 months,<br>▪ Unrepaired aortic stenosis,<br>▪ Restrictive cardiomyopathy<br>▪ Current (within past 7 days) anticoagulant therapy | ▪ Myocardial infarction in the past 6 months<br>▪ Untreated or unevaluated arrhythmia<br>▪ Currently symptomatic pulmonary disease including shortness of breath or difficulty breathing. |

**Component Order: Enter the quantity requesting**

☐ Autologous ☐ Directed **Enter the total quantity for each component needed**.

_____ Red Blood Cells (Whole Blood is no longer available) _____ Plasma

_____ Automated Double Red Cell
Provides 2 units of red cells per collection _____ Plateletpheresis

_____ Other _____

Directed Donor Special Request: ☐ CMV Neg ☐ Irradiate ☐ Quad Pack

_____ _____
Print Physician Name Physician Signature

_____ _____
Date Physician Phone Number

## Center Use Only

Date order received _____ Donor ID _____ Patient ID _____

Protocol #(s) _____ _____

**Notification of Positive Markers**

Physician/designee _____ _____ _____
Name Date EC

Transfusion Facility _____ _____ _____
Name Date EC

Facility Accept Units ☐ Yes ☐ No

| DIN | DIN | DIN | DIN |
|---|---|---|---|

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Center Information:

## Directed Donations Only Section – Patient Informed Consent

Patient Name _____

I understand that a charge for the special handling required for directed donations is added to the processing fee, even if I do not use the blood. I understand that plasma components from donors who have been pregnant may not be available for transfusion. I understand that if I am a female patient of childbearing age that it is **NOT** recommended that my husband or significant other donate for me. I understand that it is recommended that donated blood from blood relative be irradiated and there will be a fee added for this to the unit. I understand that if the donated blood is not needed for the designated recipient it may be released and become part of the community blood supply. I also understand that the names of directed donors are **NOT** released to me or to my physician. Only the number of units available will be released. The following people have been contacted and authorized by me to donate on my behalf.

**Consentimiento Informado Del Paciente**
Comprendo que una cuota por el papeleo especial que se requiere en el caso de donativos de preferencia será agregada a la tarifa de procesamiento aún si las sangre no sea utilizada por mí. Entiendo que los componantes de plasma de los donantes que han estado embarazadas no estarán disponibles para transfusion. Comprendo que si soy paciente del sexo femenino en edad de tener niños. NO se recomienda que mí esposo o campanero sexual done por mí. Comprendo que se recomienda que la sangre donada por parientes consanguineous sea irradiada y que por este procedimiento habrá una cuota adicional agregada a la unidad de sangre. Comprendo que sí la sangre donada no se necesita por el recipiente designado quedará libre y tal vez formará parte del banco de sangre comunal. Comprendo también que los nombres del los donates especificados no se harán saber ni a mí médico. Solamente se dará a saber el número de unidades disponibles. Me he puesto en contacto con las siguientes personas y las he autorizado a donor sangre a mí favor.

| Patient's Signature (Parent or legal guardian if patient is a minor)<br>Firma Del Paciente | Date<br>Fecha | Phone Number<br>Num. De teléfono |
|---|---|---|

Sufficient time must be allowed prior to surgery to draw donors. Call the Local Center for information.

| | | | **Center Use Only** | |
|---|---|---|---|---|
| Donor Name | Blood Type | Is the donor a blood relative? | DIN | Date of Draw |
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