Physician Request for Autologous Donations

I request that autologous units be collected for the following patient. I will instruct the patient to call (513) 558-1322 to schedule an appointment. I understand that final acceptance of the patient is the decision of Hoxworth Blood Center.

Patient Name _____ Date of Birth _____ Last 4 Digits SS# _____

Type of Surgery or Reason for Transfusion _____ Medicare: Yes or No

Surgery/Transfusion Date _____ Hospital _____ Hospital ID# _____

Current Medications _____

Number & Type of Units Requested*
(*Unless otherwise specified, packed red blood cells are provided for autologous transfusions.)

#_____ Whole blood #_____ Packed Red Blood Cells #_____ Cryoprecipitate

#_____ Fresh Frozen Plasma #_____ Other Component, please specify _____

Requesting Surgeon Name (print) _____ Phone _____

Address _____

Surgeon Signature _____ Date _____

Autologous units that test confirmed positive for anti-HIV-1/2, HBsAg, anti-HCV, or anti-T.cruzi (Chagas) are discarded. Autologous units that test positive on the Nucleic Acid Amplification Test (NAT) test for HIV, HCV, HBV, or West Nile Virus are discarded. Indiana state law prohibits the issue of units that test positive for anti-HIV-1/2. Autologous units with other positive test result(s) will display a "BIOHAZARD" as well as the customary "AUTOLOGOUS" label. The hospital blood bank and ordering physician will be notified of positive test results when testing is complete. If the blood is excluded from transfusion due to a positive test, the hospital blood bank will be informed that the blood will not be available.

Medical Release for Autologous Donations

Patients with significant medical conditions are required to have a physician's written release stating the specific diagnosis and that the patient is suitable to donate and there are no risks of complications should the patient experience a vasovagal (hypotensive) reaction or seizure (increased intracranial pressure) during the donation. Contraindications include: sepsis/active infection, unstable angina, MI within the previous six weeks, severe aortic stenosis, sustained ventricular tachycardia, severe left main coronary artery stenosis, congestive heart failure, aneurysm, stroke, transient ischemic attacks and chronic lung disease. The Medical Director, Hoxworth Blood Center may be contacted for advice on the safety of donation for individual patients.

Medical Condition _____

By my signature, I consider this patient's medical condition satisfactory for autologous donation(s).

Physician/Special Practitioner (print) _____ Phone _____

Physician/Special Practitioner Signature _____ Date _____

Mail/fax the completed form to Hoxworth Blood Center
(Attention: Donor Services Quality Assurance), or patient may bring to first donation.
Hoxworth Blood Center • Donor Services Quality Assurance• 3130 Highland Avenue• Cincinnati, Ohio 45267-0055
Phone (513) 558-1322• Fax (513) 558-8020
www.hoxworth.org