DIRECTED DONATION ORDER

Date: ________________________

To: South Texas Blood & Tissue Center
Fax #: (210) 731-5501

PATIENT INFORMATION

Name: ______________________________	Social Sec. No.: ______________________
Address: ____________________________ ____________________________	Date of Birth: ________________________
	Blood Type (if known): __________________
Home Phone: (____)____________________	Determined By: ________________________
Work Phone: (____)____________________	Atypical Antibody? ☐ Yes ☐ No If Yes, describe:______________________
Diagnosis: ____	

Surgery	Physician
Date: ______________________________	Name: ______________________________
Hospital: ___________________________	Address: ____________________________
City: ______________________________	Office Phone: __________ FAX: __________

Please check the component(s) required and indicate number of units.

Component	Number of Units Requested
☐ Leuko-Reduced Red Cells	__________
☐ Dual Red Cells (Leuko-Reduced)	__________
☐ Single Donor Platelets (Leuko-Reduced)	__________
☐ Other: ______________________	__________

Please check below for any special instructions.

Special Orders	Component Modification
☐ Whole Blood	☐ Irradiate
☐ Fresh Frozen Plasma	☐ Other: ____________________________
☐ CMV Testing	

Physician Signature: ______________________________

APPROPRIATE APPOINTMENTS FOR DESIGNATED DONORS AND THE PATIENT (IF NECESSARY) WILL BE SCHEDULED UPON RECEIPT OF THE COMPLETED ORDER.

Patient Name: ________________________ *DIRECTED DONATION ORDER*

COLLECTION RECORD

DATE	UNIT NUMBER	Acceptable	Unacceptable