 PHYSICIAN’S REQUEST FOR AUTOLOGOUS DONATION

For more information on autologous donations, please contact your local blood donation center.

Forms must be returned by fax or email to your local blood donation center.

Donations must be scheduled ahead of time in order to assure accurate and timely service; no walk-ins, please.
Section I: Patient Information and Request (to be Completed by Physician’s Office)

Patient’s Name ___________________________ Sex _______ Date of Birth ______________________

Last   First

Address ________________________________________________________________________________

Phone Number ___________________________ Social Security # _______ / _______ / _______

Section II: Physician’s Order (to be Completed by Physician’s Office)

Date of Anticipated Transfusion/Surgery _______________ Hospital ___________________________ Number of Units ______

Intended Procedure __________________________________________

Process as □ Leuko-reduced RBC □ Other __________

Please check any of the following medical problems that might adversely affect patient’s tolerance to blood donation

□ Heart Disease □ Chronic Lung Disease □ Seizure Disorder □ CVA □ TIA

Patient’s Current Medications __________________________________________

Physician’s Printed Name ___________________________ Office Phone ___________________________

Physician’s Signature ___________________________ Date ___________________________

Section III: To be Completed by The Blood Connection

The Blood Connection Work Instructions
1. Review section I and section II for completion.
2. Obtain physician / medical director approval for any adverse medical conditions listed.
3. Complete section III
4. Note any pertinent information (i.e. appendix written, physician verbal approval obtained, etc.) related to collection on comments line.

Social Security Number Verbally Verified by Patient/Donor □ Yes □ No □ Tech Code __________

Receiving Facility ___________________________ Ship to Facility ___________________________

Phone # ___________________________ Contact ___________________________

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<th>Unit Number</th>
<th>1st Stick</th>
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Comments _______________________________________________________

Route form: Special Donations Coordinator  Route Copy: Hospital Services in zip lock bag with unit

EFFECTIVE – F.DS.1600B: 7.0 The Blood Connection Piedmont S.C. 29673 11/30/17 –
FIND A LOCATION NEAR YOU

**Asheville Donation Center**  
225 Airport Rd. Arden, NC 28704  
Tel. 828.585.8060  
Fax 828.585.8070  
Email ashevillecollections@thebloodconnection.org

**Easley Donation Center**  
5116 Calhoun Memorial Hwy. Easley, SC 29640  
Tel. 864.644.0030  
Fax 864.644.0034  
Email easleycollections@thebloodconnection.org

**Glenwood Donation Center**  
5925 Glenwood Ave. Suite #150 Raleigh, NC 27612  
Tel. 984.222.1101  
Fax 984.222.1090  
Email raleighcollections@thebloodconnection.org

**Greenville Donation Center**  
435 Woodruff Rd. Greenville, SC 29607  
Tel. 864.232.8437  
Fax 864.527.2063  
Email greenvillecollections@thebloodconnection.org

**Greenwood Donation Center**  
341 Old Abbeville Hwy. Greenwood, SC 29646  
Tel. 864.227.8333  
Fax 864.953.9971  
Email greenwoodcollections@thebloodconnection.org

**Seneca Donation Center**  
1308 Sandifer Blvd. Seneca, SC 29678  
Tel. 864.882.8364  
Fax 864.882.8403  
Email oconeecollections@thebloodconnection.org

**Spartanburg Donation Center**  
270 N. Grove Medical Park Dr. Spartanburg, SC 29303  
Tel. 864.641.6013  
Fax 864.573.4189  
Email spartanburgcollections@thebloodconnection.org