

United Blood Services, Central Coast  
Community Blood Bank, Rancho Mirage

Autologous Donation Processing Form

**FAX all order forms to 805-922-8751**

For information, please speak with Autologous Coordinator at 805-345-3013 or 888-577-5770

DONOR #: \_\_\_\_\_ (FOR BLOOD BANK USE ONLY)  
PATIENT'S NAME: \_\_\_\_\_ SS #: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ DOB: \_\_\_\_\_  
CITY/STATE/ZIP: \_\_\_\_\_ TEL. #: \_\_\_\_\_  
HOSPITAL: \_\_\_\_\_ CITY: \_\_\_\_\_  
SURGEON: \_\_\_\_\_ TEL. #: \_\_\_\_\_  
SURGERY DATE : \_\_\_\_\_ PROCEDURE : \_\_\_\_\_  
# OF: PACKED CELLS \_\_\_\_\_ FFP \_\_\_\_\_ OTHER (SPECIFY) \_\_\_\_\_

Orders must be received 3 weeks prior to the scheduled surgery/usage date.  
Red cell apheresis may be used for collections unless specifically ordered otherwise.  
CERTAIN MEDICAL CONDITIONS MAY PRECLUDE DONATION. FINAL RESPONSIBILITY FOR  
DETERMINING SUITABILITY LIES WITH THE MEDICAL DIRECTOR OF UNITED BLOOD SERVICES.  
**United Blood Services will contact your patient to arrange appointments.**  
**Please ask your patient to *not* call the blood bank.**

SURGEON'S SIGNATURE: \_\_\_\_\_ Date \_\_\_\_\_

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FOR BLOOD BANK USE ONLY  
Medications:

Primary MD: \_\_\_\_\_ Phone # \_\_\_\_\_

\_\_\_ COLD/FLU \_\_\_ DRAINS / CATHETERS \_\_\_ FLUID/EAT \_\_\_ WT/HT \_\_\_ ID/MEDICARE CARD

\_\_\_ A0 \_\_\_ A1 \_\_\_ A3 \_\_\_ A4 \_\_\_ OTHER \_\_\_ SHIPPING FEE \_\_\_ AMOUNT

Hematocrits (informational only):  
Date \_\_\_\_\_ HCT \_\_\_\_\_ Date \_\_\_\_\_ HCT \_\_\_\_\_ Date \_\_\_\_\_ HCT \_\_\_\_\_  
Comments:

Medical Director Approval (if applicable) \_\_\_\_\_ EC/Date Input by: \_\_\_\_\_ EC/Date