

Special Collections Request

Patient Name	Last	First	Middle	Gender	Date of Birth
Patient Address (St., City, State, Zip)					
Patient Phone Number					
Hospital/Customer where components will be transfused					
Hospital Address (St., City, State, Zip)					
Ordering Physician Name					
Date of Order					
Date of Surgery or Transfusion Need					
Type of Surgery					
Patient ABO/Rh (required for directed donations)					

Type of Donation	
<input type="checkbox"/> Autologous (specify components below)	<input type="checkbox"/> Directed (specify components below)
Auto Component Order (Check type, list # needed) <input type="checkbox"/> RBC (42 day expiration) _____ <input type="checkbox"/> RBC and Liquid Plasma attached _____ <input type="checkbox"/> Whole Blood (35 or 21 day expiration) _____ <input type="checkbox"/> Apheresis Plasma _____ <input type="checkbox"/> Platelets, Apheresis _____ <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Automated Double RBC (42 day exp _____)	Directed Component Order (Check type, list # needed) <input type="checkbox"/> RBC, Leukocytes reduced, (42 day exp) _____ <input type="checkbox"/> Platelets _____ <input type="checkbox"/> Cryoprecipitate _____ <input type="checkbox"/> Fresh Frozen Plasma _____ <input type="checkbox"/> Platelets, Pheresis _____ Special Requests <input type="checkbox"/> CMV Negative <input type="checkbox"/> Quad Pack <input type="checkbox"/> Irradiate cellular components

Information for Autologous Donations Only
Complete as Applicable or Attach List of Patient's Medical Conditions
Donor's Weight:
Conditions indicative of infections:
Cardiovascular/Pulmonary Disease:
Seizures/Stroke/Transient Ischemic Attacks:
Physical Limitations (wheelchair, walker, etc.):
Current Medications/Indications:
Other:

Physician Order: (Completed by physician only)
 I have evaluated my patient, and find that the benefits of the above donation(s) outweigh the risk and authorize the unit(s) requested above to be collected.

Physician Name _____	Physician Signature/Date _____
Physician Phone Number _____	Physician Address _____

UBS USE ONLY									
Protocol Generation									
Date Order Received									
Progesa ID		Protocol Number			Patient Number				
Keyed Date		EC		Protocol Cancelled Date		EC			
Physician Notification of Positive Markers				Transfusion Facility Notification of Positive Markers					
Person Notified of (+) Results				Person Notified of (+) Results					
Date		EC		Date		EC			
Person Notified of Donor Deferred Status				Facility Accepted Unit? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Date		EC							
Autologous DIN		Date	Hct/Hgb	EC	Autologous DIN		Date	Hct/Hgb	EC

