MISSISSIPPI VALLEY REGIONAL BLOOD CENTER

P-020: DIRECTED DONATION ORDER FORM

This form must be completed and signed by the patient's physician prior to scheduling.

Patient Last Name ______________________________First Name: __________________MI:______

Date of Birth: ______________ Address: ____

Phone Number: __________________ Cell Number: _________________ Work Number: _________

ABO/Rh Type: _________
Current Antibody Screen: _________________ If positive, indicate antibody identification:_______________

Previous Antibody Screen:_________________ If previous antibody has been identified, indicate identification:_________________

Indication for Blood Transfusion: ____
Anticipated Perioperative Blood Loss: Yes No If No, reason for orders: ___________________________
____

Date Required: ________________ Hospital: ____
Number of Units: ______________ Address: ____

Directed units will be prepared as leukoreduced packed red blood cells to prevent febrile non-hemolytic transfusion reactions and transmission of cytomegalovirus (CMV).

Does your patient require: CMV Seronegative Component? ____Yes ___ No

Infant RBC Transfusion use: (circle one) Additive (AS-5) or CPD

If female, is the patient fertile? ___Yes ___ No

If the patient is a fertile woman, the Blood Center strongly recommends against the use of a donor who might potentially impregnate the patient, or any first-degree relative(s) of such donors, due to the risk of hemolytic disease of the newborn following sensitization to paternal antigens not detected in routine testing.

I, ____________________________________, have discussed the Blood Center's position on directed donations with my patient, _________________________________, and advised my patient of alternatives to directed donation including autologous pre-deposit. I am aware that directed donor products will be irradiated to minimize the risk of transfusion associated graft versus host disease. A minimum of 14 working days are required to obtain and prepare blood from directed donors. Units needed sooner will require a blood center physician approval.

Physician Signature: ____ Date: ______________

Physician (print legibly): ____

Phone Number: ________________________________ Fax Number: ____________________

Blood Center Physician: ____ Date: _____________

PLEASE FAX COMPLETED ORDER FORM TO: 563 823-8941

Mississippi Valley Regional Blood Center
Davenport IA 563-359-5401
1-800-747-5401

Central Illinois Community Blood Center
Springfield IL 217-753-1530
1-866-448-3253

Community Blood Services of Illinois
Urbana IL 217-367-2202
1-800-217-4483