South Texas Blood & Tissue Center

"Serving the community for over 30 years"

DIRECTED DONATION ORDER

Date: _____ To: South Texas Blood & Tissue Center

(THIS PAGE TO BE COMPLETED BY PHYSICIAN)

PATIENT INFORMATION

Name: _____ Social Sec. No.: _____

Address: _____ Date of Birth: _____

_____ Blood Type (if known): _____

Home Phone: (____)_____ Atypical Antibody? ☐ Yes ☐ No If Yes, describe:

Work Phone: (____)_____ _____

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
☐ Packed Red Cells	_____
☐ Dual Red Blood Cells	_____
☐ Single Donor Platelets	_____
☐ Other: _____	_____

Please check below for any special instructions.

Special Orders	Component Modification
☐ Whole Blood ☐ CMV Testing	☐ Irradiate
☐ Random Platelets	☐ Freeze
☐ Fresh Frozen Plasma	☐ Red Cell Antigen Screen
	☐ Other: _____

Physician Signature: _____

FAX COMPLETED FORM TO: San Antonio Headquarters (210) 731-5501

APPROPRIATE APPOINTMENTS FOR PATIENT AND DONORS WILL BE MADE UPON RECEIPT OF THE ABOVE INFORMATION.

COLLECTION RECORD

DATE	UNIT NUMBER	DATE	UNIT NUMBER

(continued on next page)

Main Office: 6211 IH 10 West at First Part Ten Blvd. • San Antonio, Texas 78201 • (210) 731-5555 • 1-800-292-5534 • FAX (210) 731-5505
Victoria Branch: 1109 Sam Houston Drive • Victoria, Texas 77901 • (361) 576-3651 • 1-800-345-4967 • FAX (361) 573-1621

(THIS PAGE TO BE COMPLETED BY PATIENT)

My physician has carefully explained and I fully understand the directed donation requirements and procedure. Only the following people have been contacted and authorized by me to donate blood on my behalf. *

DONOR NAME(S)	BLOOD RELATIVE?
_____	☐ Yes ☐ No
_____	☐ Yes ☐ No
_____	☐ Yes ☐ No
_____	☐ Yes ☐ No

* **NOTE**: Women of child bearing age should not be the recipients of blood donated by their children, their husbands, or their husband's blood relatives, as this could cause red blood cell alloimmunization in future pregnancies.

_____ _____

Patient's Signature (if patient is underage, parent or guardian's signature) Date

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