

AUTOLOGOUS TRANSFUSION ORDER

Signed Physician's order must be faxed to STBTC no later than 15 days prior to scheduled transfusion date. Autologous donors must schedule donation appointment no later than 10 days prior to surgery/transfusion date. Failure to schedule an appointment can result in units not being available. Appropriate appointments for autologous donors will be made upon receipt of completed Autologous Transfusion Order.

Fax completed orders to San Antonio Headquarters, (210) 731-5501.

Date: _____ To: South Texas Blood & Tissue Center

(THIS PAGE TO BE COMPLETED BY PHYSICIAN)

PATIENT INFORMATION		STBTC Patient ID #: _____	
Name: _____			
<small>Last</small>	<small>First</small>	<small>Middle Initial</small>	
Social Sec. No.: _____		Date of Birth: _____	
Address: _____			
<small>Street</small>	<small>Apt. #</small>	<small>City</small>	<small>State</small>
Home Phone: () _____		Work Phone: () _____	
Diagnosis: _____			
Surgery Date: _____		Hospital: _____ City: _____	
Patient Weight: _____			
Does this patient have a history of bacteremia or any cardiac, renal, or respiratory disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, explain: _____			
Patient Current Medications: _____			
PHYSICIAN INFORMATION			
Name: _____		Office Phone: _____	
Address: _____		FAX: _____	
Physician Signature (or authorized designee): _____			
Please check the component(s) required and indicate number of units:		Please check below for any special instructions or modifications:	
Units Requested	Component	Special Orders:	Component Modification:
_____	<input type="checkbox"/> Packed Red Cells	<input type="checkbox"/> Whole Blood	<input type="checkbox"/> Freeze
_____	<input type="checkbox"/> Dual Red Blood Cells	<input type="checkbox"/> Cryoprecipitate	<input type="checkbox"/> Other: _____
_____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____

COLLECTION RECORD

DATE	UNIT NUMBER	DATE	UNIT NUMBER

