

DIRECTED DONATION ORDER

Date: _____

To: South Texas Blood & Tissue Center
Fax #: (210) 731-5501

PATIENT INFORMATION	
Name: _____	Social Sec. No.: _____
Address: _____ _____	Date of Birth: _____
Home Phone: (____) _____	Blood Type (if known): _____
Work Phone: (____) _____	Determined By: _____
	Atypical Antibody? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, describe: _____
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
<input type="checkbox"/> Leuko-Reduced Red Cells	_____
<input type="checkbox"/> Dual Red Cells (Leuko-Reduced)	_____
<input type="checkbox"/> Single Donor Platelets (Leuko-Reduced)	_____
<input type="checkbox"/> Other: _____	_____

Please check below for any special instructions.

Special Orders	Component Modification
<input type="checkbox"/> Whole Blood	<input type="checkbox"/> Irradiate
<input type="checkbox"/> Fresh Frozen Plasma	<input type="checkbox"/> Other: _____
<input type="checkbox"/> CMV Testing	

Physician Signature: _____

APPROPRIATE APPOINTMENTS FOR DESIGNATED DONORS AND THE PATIENT (IF NECESSARY) WILL BE SCHEDULED UPON RECEIPT OF THE COMPLETED ORDER.



Patient Name: _____ **DIRECTED DONATION ORDER**

COLLECTION RECORD

DATE	UNIT NUMBER	Acceptable	Unacceptable

