Mississippi Blood Services   Jackson, Ms

PHYSICIAN'S REQUEST FOR SPECIAL SERVICES BLOOD COLLECTIONS

Directed / Autologous / Therapeutic

Patient Last Name	**First Name**	**Middle Initial**	**Date of Birth**

Home Address/City/State/Zip	**Home Phone** ( )	**Business Phone** ( )

Date of Surgery	**Hospital Name**	**Diagnosis/Surgical Procedure**
Blood Type	**City/State**	

Donation Type	**Component Type**	**Number of Units**	***For Therapeutic Donors only:***
☐ Autologous	☐ Red Cells	_______________	Donor's HCT range requiring phlebotomy _____________%
☐ Directed	☐ Whole Blood	_______________	
☐ Therapeutic	☐ Other ___________	_______________	Frequency of Donation
Test for CMV: ☐ Yes ☐ No	☐ Other____________	_______________	____________________

Directed Donor Approval

Patient Consent (to be completed by the patient or legal guardian) I understand that a charge for the special handling required for directed donations is added to the processing fee, even if I do not use the blood. I understand that is it recommended that donated blood from blood relatives be irradiated to prevent Graft vs. Host Disease and there will be an irradiation fee added for units donated by blood relatives. I understand that if any donated blood is not needed it will be released and become part of general inventory. I also understand that for confidentiality reasons, the names of actual blood donors are NOT released to me or to my physician. Only the number of units available will be released. The following people have been contacted and authorized by me to donate on my behalf. I understand that I will be notified of potential donors not listed, to give my consent.

Patient/Legal Guardian Signature ________________________________ **Contact Number** ________________ **Date** _____________

Donor Names	**Relationship to Patient**
1. ______________________________	1. ______________________________
2. ______________________________	2. ______________________________
3. ______________________________	3. ______________________________
4. ______________________________	4. ______________________________
5. ______________________________	5. ______________________________
6. ______________________________	6. ______________________________

Physician's Approval

Note for Autologous Donations: By signing this order, I attest that I consider this donor/patient's heart health (patients with history of cardiac/cardiovascular disease) and overall general health sufficient for him/her to serve as an autologous blood donor for the planned surgical procedure.

Office Contact __________________________________ **Phone** ( ) __________________ **Fax** ( ) __________________

Ordering Physician's Signature ____ **Date** ____________________

Ordering Physician (print name) ____

For Mississippi Blood Services Use:

Unit Number	Expiration Date	Irradiation Required	Unit Number	Expiration Date	Irradiation Required

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