

Autologous Request Form

Section 1 – Patient Information				
Please fill out this section completely. This information is needed to ensure proper labeling and delivery of blood products.				
Patient's Legal Name, Last:		First:		Middle:
Date of Birth:		Social Security Number:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address:		City:		State: Zip:
Weight:		Home Phone:		Work Phone:
Blood Bank of Alaska will contact the patient for pre-registration information and to schedule blood collection appointments.				
Section 2 – Doctor's Orders				
Ordering physician must complete and sign.				
Procedure:			Surgery Date:	
Surgery Facility:		City:		State: If outside Alaska, complete Section 4.
Blood Products Requested		Number of Units:		Special Instructions:
<input type="checkbox"/> Packed Red Blood Cells		_____		
<input type="checkbox"/> Other (specify):		_____		
Does patient have a history of:		Epilepsy / Seizures?		<input type="checkbox"/> Yes* <input type="checkbox"/> No
		Stroke?		<input type="checkbox"/> Yes* <input type="checkbox"/> No
		Cardiovascular problems?		<input type="checkbox"/> Yes* <input type="checkbox"/> No
		Hepatitis or liver disease?		<input type="checkbox"/> Yes* <input type="checkbox"/> No
Has the patient been prescribed anti-coagulant medication in the last 30 days (ie, Warafin, Heparin)?			<input type="checkbox"/> Yes* <input type="checkbox"/> No Anti-coagulation medication:	
*If "Yes" to any of the above conditions, the patient's personal physician must complete Section 3.				
Ordering physician's name (please print):			Office Phone:	
Ordering physician's signature:			Date:	
Section 3 – Fitness Confirmation for Autologous Donors				
Patient's personal physician must complete and sign this section only if a patient has a history of epilepsy, seizures, stroke, cardiovascular problems, hepatitis, liver disease or recent anti-coagulant medication prescription.				
Brief history and diagnosis:				
Can the patient tolerate withdrawal of up to 500 mL whole blood in 5 minutes? <input type="checkbox"/> Yes <input type="checkbox"/> No				
I have evaluated _____ (patient's name) and I agree that this patient is able to donate the number of units prescribed for transfusion as indicated.				
Physician's name (please print):			Office Phone:	
Physician's signature:			Date:	
Section 4 – Blood Delivery Instructions				
Ordering physician must complete for out-of-state shipments only.				
Name of surgery facility:			Phone Number:	
Shipping address:		City:		State: Zip:
Blood Bank of Alaska Staff Only				
Patient Number:	Donor Number:	ARF info verified by:	Data proofed by:	Date: