Blood Bank of Alaska
Helping Alaska patients in need

1215 Airport Heights Dr. • Anchorage, AK 99508 • Tel: 907-222-5600 • Fax: 907-563-1371 • www.bloodbankofalaska.org

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: ☐ Male ☐ 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:

☐ Packed Red Blood Cells _____

☐ Other (specify): _____

Does patient have a history of:

Epilepsy/seizures?	☐ Yes*	☐ No
Stroke?	☐ Yes*	☐ No
Cardiovascular problems?	☐ Yes*	☐ No
Hepatitis or liver disease?	☐ Yes*	☐ No

Has the patient been prescribed anti-coagulant medication in the last 30 days (eg, Warafin, Heparin)? ☐ Yes* ☐ 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 of whole blood in 5 minutes? ☐ Yes ☐ 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: ☐ Added Attribute in LT	Data Proofed By:	Date: