NewYork BloodCenter

PHYSICIAN'S ORDER FORM

Autologous & Directed Donations

Patient Information — *All Information Must Match Hospital Records*

Name: _____ _____ _____
LAST FIRST MI

Birth Date _____ ID# _____ Gender: Male ☐ Female ☐

Address _____

City _____ State _____ Zip Code _____ Phone # _____ _____
DAYTIME EVENING

Hospital Information — *Do Not Abbreviate*

Scheduled Date of Surgery _____

Patient's Blood Type _____ Surgical Procedure/Diagnosis _____

Facility Name _____ City/State/Zip _____

Ordering Physician Information

Name: _____ _____ Phone # _____ Fax # _____
LAST FIRST

Physician's Signature: _____ Date: _____

Address _____ City _____ State ____ Zip _____

Autologous Units Requested:
(*Please Write Number of Each Product Requested*)

____Red blood cells
____Platelets
____Plasma
____**Other** (please specify)_____

Directed Units Requested:
(*Please Write Number of Each Product Requested*)

____Red Blood Cells
____Platelets
____Plasma

☐ **Other Product Requests** (please specify)_____

NOTE: All directed units will be irradiated unless otherwise requested by the hospital.

Physician's Preassessment for Autologous Donors Only:

Medical Clearance: Please complete the following information regarding the patient's medical status and provide **all** medical conditions and medications (list can be continued on an additional sheet).

Past or Present Medical Conditions: _____

_____

_____

_____

Medication: _____

_____

_____

_____

By signing below, you confirm that your patient does not have any significant cardio or cerebrovascular, pulmonary or other disease that would serve as medically contraindicated to donation.

Physician's Signature: _____ **Date:** _____ **NYBC Approval:** _____
(STAMPED SIGNATURES WILL NOT BE ACCEPTED) *(Initial & Date)*

FOR MORE INFORMATION, PLEASE CALL (800) 439-6876 **FAX COMPLETED ORDERS TO (516) 334-4936**