COMMUNITY
BLOOD BANK
2646 Peach Street
Erie, PA 16508

DIRECTED DONATION ORDER

Date: _____

PLEASE PRINT LEGIBLY

PATIENT INFORMATION			
Last	First		MI
Date of Birth	SS#		Gender ☐ M ☐F
Address			
City	State		Zip
Daytime Phone	Evening Phone	Cell Phone	

PATIENT INFORMED CONSENT

I have elected to provide blood for my own transfusion needs through the use of directed donations.
I understand the following:

- It is my responsibility to procure the donors.
- Directed donors must schedule appointments for donation at least 5 working days prior to the anticipated need.
- This is not an emergency or stat process
- Directed donations have not been shown to be any safer than blood from volunteer blood donors
- Directed donors will be qualified in the same manner as volunteer blood donors
- I have no right to know which directed donor's blood I will be receiving.
- I have no right to receive the name or any other information of any kind from Community Blood Bank concerning the donation process, the donation result, or blood test results of the donors designated by me or any other donor whose blood I may use.
- If a directed donor's blood cannot be released, my physician will be notified of its unavailability. The physician will not be told the reason why it is not available.

Signature of Patient: _____ Date: _____

Signature of Parent/Guardian if patient is a minor: _____

Relationship to patient: _____

HOSPITAL INFORMATION	
Hospital Name	
Date of Surgery or Transfusion Need:	
Patient Blood Type: **(REQUIRED)**	Patient Hospital MR#:

Complete and Return Both Pages

Fax completed order to: (814) 452-3966
Please call (814) 456-4206 for questions or to schedule appointments

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DIRECTED DONATION ORDER

PATIENT NAME: _____

PHYSICIAN INFORMATION			
Last Name			First Name
Address			Phone #
City	State	Zip	Fax #

COMPONENT (s) REQUESTED	NUMBER OF UNITS REQUESTED
☐ Leuko-Reduced Red Blood Cells	_____
☐ Red Blood Cells	_____
☐ Single Donor Platelets (Leuko-Reduced)	_____
☐ Whole Blood	_____
☐ Other: _____	_____

SPECIAL ORDER

☐ CMV Negative ☐ QUAD PACK (neonatal transfusion)

PHYSICIAN SIGNATURE: _____ **DATE:** _____

Fax completed order to: (814) 452-3966
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COMMUNITY
BLOOD BANK

A Member of America's Blood Centers

Our Donors Save Lives

DIRECTED DONOR INFORMED CONSENT

I give my permission for the collection of a unit of blood for potential transfusion to the following patient:

Patient Name: _____

Date Required: _____

I understand:

1. Some of the risks involved and possible complications from blood donation may include but are not limited to: arm bruises, nerve injury, fainting, anemia or iron deficiency. I understand that if these should occur, I should contact CBB or my personal physician.

2. I consent to blood screening tests, which include, but are not limited to: tests for hepatitis B and C, Human Immunodeficiency Virus, other retroviruses, and syphilis.

3. A positive test result from any of these tests will result in the blood I donate being unacceptable for transfusion. If this positive test indicates that I should no longer donate blood, I will be notified and my name will be placed on a confidential deferral list. I understand that CBB will comply with all federal, state and local regulations and laws regarding reporting of positive tests. Test results will be kept confidential.

4. I understand that if my blood is not used for the intended patient that it may be crossed into the general inventory and used for another patient.

I have read the Educational Materials and have had the opportunity to ask questions. *At this time, all questions have been answered to my satisfaction.*

I voluntarily consent to the withdrawal of blood by authorized members of the staff of the Community Blood Bank of Erie County for the purpose of directed donation for the patient listed above.

NAME (PRINT) _____ ID # _____

DONOR SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____

2646 Peach Street · Erie, PA 16508-1895 · Phone (814) 456-4206 · Fax (814) 452-3966