



**DIRECTED DONATION ORDER**

Date: \_\_\_\_\_

PLEASE PRINT LEGIBLY

PATIENT INFORMATION			
Last		First	MI
Date of Birth	SS#		Gender
Address			<input type="checkbox"/> M <input type="checkbox"/> F
City		State	Zip
Daytime Phone	Evening Phone	Cell Phone	

PATIENT INFORMED CONSENT
<p>I have elected to provide blood for my own transfusion needs through the use of directed donations. I understand the following:</p> <ul style="list-style-type: none"> <li>• It is my responsibility to procure the donors.</li> <li>• Directed donors must schedule appointments for donation at least 5 working days prior to the anticipated need.</li> <li>• This is not an emergency or stat process</li> <li>• Directed donations have not been shown to be any safer than blood from volunteer blood donors</li> <li>• Directed donors will be qualified in the same manner as volunteer blood donors</li> <li>• I have no right to know which directed donor's blood I will be receiving.</li> <li>• 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.</li> <li>• 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.</li> </ul> <p>Signature of Patient: _____ Date: _____</p> <p>Signature of Parent/Guardian if patient is a minor: _____</p> <p>Relationship to patient: _____</p>

HOSPITAL INFORMATION	
Hospital Name	
Date of Surgery or Transfusion Need:	
Patient Blood Type: <b>(REQUIRED)</b>	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

**DIRECTED DONATION ORDER**

PATIENT NAME: \_\_\_\_\_

<b>PHYSICIAN INFORMATION</b>			
Last Name			First Name
Address			Phone #
City	State	Zip	Fax #

<b>COMPONENT (s) REQUESTED</b>	<b>NUMBER OF UNITS REQUESTED</b>
<input type="checkbox"/> Leuko-Reduced Red Blood Cells	_____
<input type="checkbox"/> Red Blood Cells	_____
<input type="checkbox"/> Single Donor Platelets (Leuko-Reduced)	_____
<input type="checkbox"/> Whole Blood	_____
<input type="checkbox"/> Other: _____	_____
<b>SPECIAL ORDER</b>	
<input type="checkbox"/> CMV Negative	<input type="checkbox"/> QUAD PACK (neonatal transfusion)

PHYSICIAN SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_



COMMUNITY BLOOD BANK

A Member of America's Blood Centers

Our Donors Save Lives

DEDICATED 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: \_\_\_\_\_

Surgery Date: \_\_\_\_\_

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. My blood cannot be collected more frequently than every *three* days. I may give this frequently only while donating to *one* patient.
5. The most likely limitation of collection with this frequency will be my hemoglobin or hematocrit level. When the value falls below the minimum criteria as dictated by the FDA and AABB, I will cease donating.
6. 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.
7. CBB's Medical Director (or designee) must grant approval in order for me to donate this frequently.

I have had an 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 for the purpose of directed donation for the patient listed above.

Donor Name(PRINT) \_\_\_\_\_ ID#: \_\_\_\_\_

Donor Signature: \_\_\_\_\_ Date \_\_\_\_\_

Witness: \_\_\_\_\_ Date \_\_\_\_\_