This form contains fill-in fields and may be completed electronically

Puget Sound Blood Center research | medicine | blood & tissue services

AUTOLOGOUS BLOOD STORAGE ORDER FORM
Special Collections

1021 112th Ave NE Bellevue, WA 98004
(800) 266-4033 or (425) 453-5098 Fax (425) 462-4316

- **Please allow at least 1 week from the last unit requested to date of surgery. Late orders may be denied based on insufficient processing time or appointment availability.**
- **This order cannot be processed if any information or physician's signature is missing.**

Today's Date: _____ **Date of Surgery:** _____

Patient's Legal Name _____ _____ _____
Last First Middle Name or Initial

☐ Male ☐ Female Patient's Birthdate ____/____/_____ Patient's Hospital # _____

ABO-Rh type (optional) _____ Home Phone # (_____)_____ Work/Cell Phone # (_____)_____

Diagnosis _____ Hospital _____

Procedure _____ Number of Red Cell Units _____

Default minimum hemoglobin is 11.0g/dL (Hematocrit is 33%) If a *higher* minimum hematocrit is desired, specify ____%

Patient's Weight: _____

If your patient weighs less than 110 lbs the amount drawn will be based on your patient's weight.
If your patient weighs less than 82 lbs, Blood Center Medical Director Authorization required.

Please indicate if the patient has any of the following HIGH RISK conditions:
Some conditions will require authorization from the patient's physicians and the Puget Sound Blood Center Medical Director

PATIENT *IS NOT* ELIGIBLE TO DONATE IF HE/SHE HAS THE FOLLOWING:

☐ Osteomyelitis ☐ HBsAg or HIV positive

PATIENT *MAY NOT* BE ELIGIBLE TO DONATE IF HE/SHE HAS THE FOLLOWING:

☐ Other Chronic Bacterial Infection? If so, what is the Bacterial Infection? _____

AUTHORIZATION IS REQUIRED FROM THE PATIENT'S PHYSICIAN IF HE/SHE HAS THE FOLLOWING:

☐ Myocardial infarction or cerebrovascular accident within 6 months of donation
☐ Patients with significant cardiac or pulmonary disease

AUTHORIZATION IS REQUIRED FROM BOTH THE PATIENT'S PHYSICIAN AND THE PUGET SOUND BLOOD CENTER MEDICAL DIRECTOR IF HE/SHE HAS THE FOLLOWING:

Blood Center use only:
☐ Medical Director authorization received

☐ Aortic Stenosis ☐ Cyanotic heart disease ☐ High-grade left main coronary artery disease ☐ Subaortic Stenosis
☐ Heart Attack past month ☐ Uncontrolled seizure disorder ☐ Unstable Angina

Surgery Scheduler/Contact Person _____	Physician's full name _____
Contact Phone # _____ Ext _____	Physician's address _____
	Physician's phone # _____

Physician's Signature: _____