

Directed Donation Request

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PART 1: PROVIDER'S ORDER

I have explained the pros and cons of directed donations to said patient and have advised him/her that he/she must sign.

I request that the Marsh Regional Blood Center draw blood from donors recruited by the patient named below (or by patient's family). I understand that the blood may not be available for transfusion if collected less than 72 work-week hours before the date of intended transfusion.

<p>Date of intended transfusion: _____</p> <p>Types of products requested _____</p> <p>Number of units requested _____</p> <p>Hospital: _____</p> <p>Address: _____</p> <p>Phone: _____</p> <hr/> <p>Provider's Name (please print): _____</p> <p>Address: _____</p> <p>Phone: _____</p> <p>Fax: _____</p> <p>Provider Signature: _____</p> <p>Date Signed: _____</p>	<p>Important Notes: (please read before signing)</p> <ol style="list-style-type: none"> 1. Products expire in 28 days. 2. Units will be leukoreduced, irradiated packed red blood cells unless otherwise specified. 3. Units will not be routinely collected from donors with hematocrit values less than 38% for females and 39% for males. 4. If the donor has a history of significant cardiac or circulatory problems, a physician approval to donate may be required.
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PART II: PATIENT INFORMATION AND REQUEST

I hereby request that the Marsh Regional Blood Center draw directed donors for me. I specifically release Marsh Regional Blood Center from any liability if I am unable to recruit enough suitable donors for my use or if there are circumstances that prevent the blood recruited on my behalf from being transfused to me.

I understand that blood of the wrong type or blood that is incompatible on crossmatch cannot be given to me, that donors referred by me may be ineligible to donate and that technical problems or unsatisfactory test results may cause loss of the directed unit(s).

I agree that any blood that cannot be used by me or is not needed for the scheduled procedure will be released for the use of other patients.

Patient Name:	Date of Birth:	Medical Record Number:
Patient Address:	Patient Social Security Number:	
	Patient Telephone Number:	
Patient (Parent/Guardian Signature if a Minor):		Date Signed:

Completed form must be forwarded to Marsh Regional Blood Center, Kingsport, TN 37660

Marsh Regional Blood Center-Kingsport
111 West Stone Drive, Suite 300
Kingsport, TN 37660
Phone: 423-408-7500 Fax: 423-408-7540

Marsh Regional Blood Center-Bristol
350 Blountville Hwy, Suite 207
Bristol, TN 37620
Phone: 423-652-0014 Fax: 423-652-0048

Marsh Regional Blood Center-Johnson City
2428 Knob Creek Road, Suite 100
Johnson City TN 37604
Phone: 423-282-7090 Fax: 423-282-7099