705 E 4th St Chattanooga, TN 37403

SPECIAL DONATION REQUEST FORM

Please fax to 423-752-8484 or email to specialdonations@bloodassurance.org

I. PATIENT INFORMATION (as stated on insurance card)

☐ Male ☐ Female	Last Name:	First Name:	MI:

Street Address/P.O. Box:	City/State/Zip:	Date of Birth:

Home Phone:	Cell Phone:	Diagnosis/Surgical Procedure:

Anticipated Transfusion Date:	Transfusion Hospital:	City/State:

II. PHYSICIAN REQUEST

☐ Autologous # of units needed:________________

Autologous Donor Pre-Assessment

Does Patient have existing physical conditions that would prohibit donation? ☐ No ☐ Yes

*If checked yes, list condition:*________________

Note: Hemoglobin must be ≥ 12.5 g/dL for females; ≥ 13.0 g/dL for males

Please check past or present medical conditions:

☐ Cardiovascular or Cerebrovascular Disease
☐ Pulmonary Disease
☐ Seizures
☐ Bacteremia/Infection

☐ Directed # of units needed

☐ Red Blood Cells ________________
☐ Plateletpheresis ________________
☐ Plasma (FFP or FP24) ________________

Special Needs:

☐ CMV Negative: ________________ ________________
☐ Other: ________________ ________________

Patient's Blood Type: ________________
(Required prior to drawing donors)

I request that Blood Assurance collect Autologous and/or Directed units as specified above. I understand that missing or incomplete information can result in Blood Assurance not being able to complete the donation process.

Phone Number: ________________

Fax Number: ________________

Physician's Signature — Date — Physician's Name (please print)

III. Autologous Patient's Consent/Release of Test Results

1. I consent to the withdrawal of blood by authorized personnel at the blood center for autologous transfusion purposes and further consent to such additional procedures pursuant to autologous transfusion as may be necessary or desirable.
2. I understand that positive results may delay, or in some cases, cancel the shipment of my blood.
3. I authorize Blood Assurance to release my test results to my physician.

Patient's Signature — Date

Date	Autologous Units

Blood Assurance Use Only

BA File ID: ____________

Directed Units	Directed Units

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