Bloodworks

AUTOLOGOUS BLOOD STORAGE ORDER FORM

Special Collections

Time Square, 660 SW 39th Street, Suite 245, Renton, WA 98057

(800) 266-4033 or (425) 453-5098 Fax (425) 251-1977

- **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 Provider'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, PSBC Medical Staff or Designee Authorization is required.

Please indicate if the patient has any of the following HIGH RISK conditions:

Some conditions will require authorization from the patient's Provider and the Bloodworks Medical Director or Designee

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 PROVIDER IF HE/SHE HAS THE FOLLOWING:

❑ Myocardial infarction or cerebrovascular accident within 6 months of donation

❑ Patients with significant cardiac or pulmonary disease

Blood Center use only:

❑ Medical Director or designee authorization received

AUTHORIZATION IS REQUIRED FROM BOTH THE PATIENT'S PROVIDER AND BLOODWORKS MEDICAL DIRECTOR IF HE/SHE HAS THE FOLLOWING:

❑ 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 _____	Provider's full name _____
Contact Phone # _____ Ext _____	Provider's address _____
	Provider's phone # _____

Provider's Signature: _____