THE BLOOD CENTER

2609 Canal Street
New Orleans, LA 70119
Phone (504) 592-1562 Fax (504) 592-1568

PHYSICIAN REQUEST FOR AUTOLOGOUS BLOOD

Donor Unit No.

Instruction to the Physician: This form will be considered your prescription and should be fully completed and signed. Your patient should present this form at the time of their first donation or it may be faxed to the attention of the Autologous / Directed Donor Coordinator at (504) 592-1568 a minimum of three (3) days prior to the first donation.

PLEASE PRINT

Patient Name (Full Name, No Nickname)	Patient Birth Date	Patient ABO/Rh
Patient Address	Patient Telephone (Home)	
Patient City, State and Zip Code	Patient Telephone (Work)	
Patient Diagnosis	Patient Telephone (Cell)	

Surgical Procedure	Date of Surgery
Hospital	City and State

Blood and Blood Components Requested and the Quantity Needed

Whole Blood (35 day expiration)	_____ units	Fresh Frozen Plasma	_____ units
Red Blood Cells (42 day expiration)	_____ units	Cryoprecipitate	_____ units
Double Red Blood Cells (By Apheresis)	_____ units	Other (Specify) _____	_____ units

* If your patient qualifies, do you agree to an automated 2 units red cell collection with saline replacement? (This is an FDA approved procedure for autologous donors). ☐ Yes ☐ No

PLEASE **PRINT** ALL INFORMATION EXCEPT SIGNATURE

Doctor's Signature	Doctor's Address
Doctor's Name	City, State, Zip Code
Doctor's Telephone	Doctor's Fax

* Available by appointment at Apheresis Donor Centers only. Please call for locations.

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