THE BLOOD CENTER

1116 McKaskle Drive
Hammond, LA 70403
Phone (985) 340-2342 Fax (504) 910-8402

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 P&D Designee at (504) 910-8402 a minimum of three (3) days prior to the first donation.

PLEASE PRINT

Patient Name (Full Name, No Nickname)	Patient Birth Date
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

Red Blood Cells _____ units

☐ CPD Non-Leukocyte reduced/ No Adsol (35 day expiration)

Double Red Blood Cells _____ units

(By Apheresis) * ☐

Fresh Frozen Plasma _____ units

Cryoprecipitate _____ units

Other (Specify)

_____ _____ units

Note: If the donor has a known sickle-positive attribute, please notify TBC prior to visit. Coordinating suitable components will minimize potential product loss.

* 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

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

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