



# THE BLOOD CENTER

1116 McKaskle Drive  
Hammond, LA 70403

Phone (985) 340-2342 Fax (504) 910-8402

## PHYSICIAN REQUEST FOR DIRECTED DONOR BLOOD

Donor Unit No.

**Instruction to the Physician:** This form will be considered your prescription and should be fully completed and signed. The completed form must be presented to TBC staff upon visit of the 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 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 _____ units	Cryoprecipitate _____ units
<input type="checkbox"/> CPD, AS-1 or AS-5 additive (42 day expiration)	Other (Specify) _____
<input type="checkbox"/> CPD Non-Leukocyte reduced/ No Adsol (35 day expiration)	_____ units
Double Red Blood Cells _____ units (By Apheresis) *	
<b>Blood Attributes</b>	
<input type="checkbox"/> Sickle Cell Negative	<input type="checkbox"/> Other _____
<input type="checkbox"/> CMV Negative	_____
* 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