REQUEST FOR AUTOLOGOUS UNITS(S) TO BE FROZEN

TOP SECTION TO BE COMPLETED BY PHYSICIAN AND FAXED TO TRANSFUSION HOSPITAL

THE INTENDED DATE OF TRANSFUSION HAS BEEN POSTPONED PAST THE EXPIRATION DATE FOR AUTOLOGOUS UNITS(S)

DONATED BY _____
PATIENT/DONOR NAME

TO BE TRANSFUSED AT _____
HOSPITAL TRANSFUSION SERVICE

PLEASE RETURN THE UNIT(S) TO MEDIC TO BE FROZEN AND HELD AT MEDIC UNTIL NEEDED OR FOR A PERIOD NOT TO EXCEED 6 MONTHS FROM DATE OF COLLECTION. (**NOTE:** *Medic is not responsible for loss of unit due to freezing or deglycing procedures.)*

_____ _____
PHYSICIAN'S NAME PHONE #

_____ _____
PHYSICIAN'S SIGNATURE DATE

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TO BE COMPLETED BY TRANSFUSING HOSPITAL

PLEASE FREEZE THE FOLLOWING UNIT(S) FOR _____
PATIENT/DONOR NAME

1. _____
2. _____
3. _____
4. _____

UNIT(S) RETURNED TO MEDIC ON _____

TRANSFER MEMO# _____

SIGNED _____ DATE _____
TRANSFUSION SERVICE TECH

MEDIC REGIONAL BLOOD CENTER
1601 AILOR AVENUE
KNOXVILLE, TN 37921

MEDIC 4.363
REVISED 03/2000