# REQUEST FOR AUTOLOGOUS UNIT(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 3.910RAF
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