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

==================================================================

=

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                                                                                  MEDIC 4.363
KNOXVILLE, TN  37921                                                                      REVISED 03/2000