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 UNIT(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
REVISED 05/15/2017