**HOW CAN MY FAMILY AND FRIENDS DONATE BLOOD FOR ME?** **Directed Donation Request**

If you and your physician agree that you should recruit your own donors to provide blood for your surgery (DIRECTED TRANSFUSION), follow the steps listed below:

1. Read, fill in and sign the Patient's Request (Section 2 below).
2. Have your physician complete Section 1.
3. Have the Blood Bank at the Hospital listed in Section 1 collect a sample from you and complete Section 3.
4. Send completed form to MEDIC. Fax: (865) 521-2644. **MEDIC must have form before any donors can be drawn.**
5. Have your prospective donors call for an appointment to have their blood collected. (865) 524-3074 ext. 624

**COLLECTION GUIDELINES** Mon. – Fri., 8 am – 4:30 pm.

All donors must be scheduled at least 1 week prior to the expected transfusion date. Donors must meet all donor eligibility requirements established by MEDIC Regional Blood Center and those set forth by the State of Tennessee, federal government, and the AABB. MEDIC will collect and process the donation(s). The blood will be transferred to the hospital where the transfusion will occur. MEDIC will not notify patient or patient representatives if units are not suitable, however, MEDIC will notify the hospital transfusion service regarding the suitability of each donation. A blood service procedure fee will be charged for each unit.

## SECTION 1: PHYSICIAN'S ORDER

I request that MEDIC Regional Blood Center draw blood from donors recruited by the patient named below (or by patient's family.) The processed blood is to be available after allowing 1 week for testing and processing.

| DATE OF INTENDED TRANSFUSION | # OF DONORS | HOSPITAL |
|---|---|---|
| PHYSICIAN'S NAME<br><br>ADDRESS | | SPECIAL INSTRUCTIONS |
| TELEPHONE NUMBER | | SIGNATURE DATE |

## SECTION 2: PATIENT INFORMATION AND REQUEST

I hereby request that MEDIC Regional Blood Center draw directed donors for me. A blood service procedure fee will be charged for each unit. I understand that the number of units of blood available for transfusion to me may be less than the number of donors I recruit. This may be due to donor deferral, unacceptable test results, blood type incompatibility, or loss of units during processing or transport. I understand that the only information to be released regarding directed donations **is the number of units available for use by the recipient.** I also understand I will not be told the name(s) of the person(s) who came to donate for me nor who did or did not donate blood.

**MEDIC will not notify patient or patient representative if units are not suitable.** I agree that any blood that cannot be used by me or is not needed for my procedure may be released for use by other patients.

| PATIENT'S NAME | DATE OF BIRTH |
|---|---|
| ADDRESS | SOCIAL SECURITY NUMBER (Last 4) |
| | TELEPHONE NUMBER |
| SIGNATURE: PATIENT OR PARENT/GUARDIAN IF A MINOR | DATE SIGNED |

## SECTION 3: HOSPITAL TRANSFUSION SERVICE (MUST BE COMPLETED BEFORE DONORS CAN BE DRAWN)

| PATIENT'S ABO AND RH | ANY REMARKS? | |
|---|---|---|
| ANTIBODY SCREEN RESULTS | HOSPITAL TECHNOLOGIST SIGNATURE | DATE SIGNED |

Send completed form to MEDIC. Fax: (865) 521-2644. **MEDIC must have form before any donors can be drawn.**

MEDIC USE ONLY: PATIENT ID #: _____ SPECIAL REQUEST ID #: _____