Request for Directed Donations

LifeSouth Community Blood Centers

Section A: Patient Information

Last Name	First Name	Middle Name		SSN
Address	City	State	Zip	Phone

Blood Type	Date of Birth	Hospital Name, City, and State
Date of Surgery/Procedure		Patient Diagnosis

Donor List:

Donor Name	*Relationship to Patient*

Section B: Treating Requesting Physician

I request that this patient be approved as a recipient of directed donations.

Signature, MD:	Date:	
Physician (printed name):	Phone:	Fax:

Address:

Component Type & Number Requested*: ☐ Packed Cells; # ____________ ☐ Apheresis Platelets; # ________

☐ Other, list type: ______________________________; # : __________

Are CMV Negative components required? ☐ Yes ☐ No (***Note: All units from directed donations will be leukocyte reduced and irradiated.***)

Additional Request details:

Section C: Medical Director (or designee) Decision (completed by Medical Director or designee)

Name of Medical Director or designee:	☐ APPROVED ☐ NOT APPROVED
Signature:	Date:

Directions to staff:

Section D: Medical Office Staff Processing (if approved)

☐ Patient Enrolled in IBBIS

☐ Donations matched & order filled

Fax completed form to the Medical Office at (888) 286-0179.