

## Request for Autologous Collections

### LifeSouth Community Blood Centers

*Submit requests no later than 21 days prior to the surgery date. The Medical Office must approve requests prior to patient collection.*

#### Section A: Patient Information

Last Name		First Name	Middle Name	Sex	SSN	MR# (if applicable)
Address		City	State	Zip	Home Phone	Alternate Phone
Blood Type	Date of Birth <sup>1</sup>	Hospital		Date of Surgery		
Surgical Procedure: <input type="checkbox"/> Bilateral Hip/Knee <input type="checkbox"/> Spine, multiple levels <input type="checkbox"/> Redo hip/knee <input type="checkbox"/> Redo cardiac surgery <input type="checkbox"/> Other, please describe:					Patient Diagnosis:	
List all medications prescribed for this patient:						
Please check any past or present medical conditions that apply to this patient: <input type="checkbox"/> Cardiac/Cardiovascular Disease* <input type="checkbox"/> Arrhythmia* <input type="checkbox"/> Pulmonary Disease <input type="checkbox"/> Stroke* <input type="checkbox"/> Current Anticoagulant Therapy* <input type="checkbox"/> Seizures <input type="checkbox"/> Other (list all other conditions):						
*A written cardiac release is required for these patients. Please provide the name of the patient's cardiologist/primary physician. Please attach written approval from the listed physician for autologous blood collection.						
Cardiologist/Primary Physician Name: _____ Phone: _____						

#### Section B: Blood Components Requested

Check one: <input type="checkbox"/> Packed Cells <input type="checkbox"/> Other	Number needed: <input type="checkbox"/> 1 <input type="checkbox"/> 2
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#### Section C: Requesting Physician Signature

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

#### Section D: Blood Center Medical Office Decision

Name of Medical Director (or designee):	
<input type="checkbox"/> APPROVED for _____ units of Whole Blood --> Packed cells +/- FFP <input type="checkbox"/> NOT APPROVED	
Signature:	Date:
Comments:	

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

<sup>1</sup> Autologous donations are limited to patients from age 18 through age 65.