Clear Fields

Request for Directed Donations

LifeSouth Community Blood Centers

Section A: Patient Information

Last Name	First Name	Middle Name		Sex	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.