Community Blood Center
Community Tissue Services
Dayton, Ohio 45402

PHYSICIAN'S ORDER AND CONSENT FOR DIRECTED BLOOD DONATIONS

I have carefully read and understand the information provided by Community Blood Center ("CBC") regarding directed donations. I understand that the three major national blood banking organizations in the United States discourage directed donations and that it is their opinion that blood from directed donors is no safer than blood from the normal volunteer donor blood supply.

I hereby request that directed donations be used for the patient indicated below.

I certify that this patient or the patient's guardian or other legal representative has read and appears to understand the Directed Donation Information provided by CBC. I also certify that my patient and I understand and agree that, if this patient requires transfusion of blood products exceeding the number of directed donor units deemed suitable for transfusion by CBC, such additional products will be prepared from random volunteer donor blood and **not** from the donors recruited by this patient.

In the event that any of the donors chosen by my patient has positive laboratory test results, Community Blood Center will notify the donor in accordance with Blood Center policy.

_____ _____ _____
Patient's Name Birthdate Patient ABO/Rh Type (if known)

The patient's ABO/Rh Type is needed to properly secure Directed Donors.

Number of Units Needed_____ Transfusion Date_____

Hospital_____City/State/Zip_____

CHECK ALL THAT APPLY

PACKED RED CELLS
WHOLE BIOOD
_____

LEUKOPOOR
ABO SPECIFIC
CMV NEG

PRINT PHYSICIAN NAME_____

PHYSICIAN SIGNATURE_____

ADDRESS_____

CITY/STATE/ZIP_____

TELEPHONE #_____Fax #_____

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