Memorial Blood Centers
737 Pelham Blvd.
St. Paul, MN. 55114
Phone: 651-332-7321
Fax: 651-332-7001

Nebraska Community Blood Bank
100 N. 84th Street
Lincoln, NE 68505
Phone: 877-486-9414
Fax: 402-486-9428

Physicians Order Form for Dedicated Donation

PART I: TO BE COMPLETED BY THE PATIENT'S PHYSICIAN – PLEASE FILL OUT COMPLETELY

Please indicate the type of component(s) and the quantity of each component below.

I request Innovative Blood Resources to draw: ____________ Whole Blood ____________ Red Cells ____________ Plasma ____________ Platelets

for my patient (legal name) ____

I understand that dedicated donations are not accepted on an emergency basis. I will not be notified whether or not sufficient dedicated donations have been made. It is the responsibility of the patient, for whom I have requested these donations, to ensure that these donors present themselves to the blood center not less than three (3) working days (blood) or two (2) working days (platelets) prior to expected use. The patient and I are responsible to ensure that all patient information is correct and to notify the blood center if the date of expected use is changed.

Please check if special criteria must be met (Note: All units will be irradiated): ☐ ABO/Rh Identical units only

Date of expected use: _______/_______/________ **Blood Type (Required):** ______________________________

Hospital / City____ Blood Supplier______________________________________

Anticipated number of donations ______________ Indication(s) for Dedicated Donation: ______________________________________

Physician's name (print) ______________________________________ Telephone ____

Physician's signature ______________________________________ Date ________________________

PART II: TO BE COMPLETED BY THE PATIENT (or Parent/Guardian if patient is a minor)

My signature below attests that I have read the information given to me about dedicated donations and that I understand that blood donors selected by me are no safer than donations from other volunteers. I understand that blood from dedicated donors will not be available if:

- Donor is not eligible to donate
- Donor does not meet criteria set by my physician
- Donor blood is not compatible with my blood
- Units are broken, contaminated or not transfusable for any reason

Innovative Blood Resources cannot guarantee that dedicated units will be available. Blood donated for me is the property of the blood center. The blood center will take reasonable measures to deliver dedicated units to the hospital within a timely manner. I understand that I will be charged the standard service fees for the collection, testing and processing of these units, as well as a special handling fee. I am also responsible for shipping costs that may be incurred. I hereby request that Innovative Blood Resources draw the following dedicated donors for me/ my child.

ALL DONOR INFORMATION IS REQUIRED TO ACCEPT A DONOR

Donor Legal Name (Print)	Date of Birth	Gender	Blood Type	Phone Number

ALL INFORMATION IS REQUIRED TO ACCEPT THIS REQUEST

Patient's Legal Name: ______________________________________ Date of Birth: ______________________________

Address: ______________________________________ Telephone Number: ______________________________

City: ______________________________________ State: _______________ Zip Code: _______________

Signature of Patient (or Parent/Guardian if patient is a minor) ______________________________________

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PART III: TO BE COMPLETED BY HOSPITAL BLOOD BANK OR TRANSFUSION SERVICES – PLEASE FILL OUT COMPLETELY

Patient:____ Blood Type______________________

Patient's Date of Birth: _____/_______/_______

Anticipated date of use: _____/_______/_______

Component Information:

☐ LEUKOREDUCED AS-1 RED CELL (CPD DOUBLE)

☐ LEUKOREDUCED CPDA-1 RED CELL (CPDA-1 DOUBLE)

☐ Pediatric bags attached

☐ Other (specify) ____

____
Tech's Initials/Date

NOTE: IF COMPONENT REQUESTED IS NOT COMPLETED, UNIT WILL BE DRAWN AS A LEUKOREDUCED AS-1 UNIT

Donors need to present themselves to the blood center not less than three (3) working days (blood) and two (2) working days (platelets) prior to expected use.

IBR Physician Services Use Only

Physician Comments ____
____
____
____

_____ Approved _____ Not Approved Frequency of Donation________________________

____ ______________________
IBR Physician Signature **Date**

IBR Collection Staff Use Only

- Prior to blood collection contact IBR Physician to evaluate donor.

________________________________ ___________________________ _______________
Name of Approving Physician **Collection staff obtaining approval** **Date**