Innovative Blood Resources
737 Pelham Boulevard
Saint Paul, MN 55114
Phone: 651-332-7321
Fax: 651-332-7029

Physicians Order Form for Directed Donation

NOTE: All sections (front and back) must be completed before order can be processed.

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 (packed cells) ☐ Other (Specify) ______________________ Quantity __________

for my patient (legal name) ____

I understand that directed donations are not accepted on an emergency basis. I will not be notified whether or not sufficient directed 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 seven (7) working days 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: _______ / _______ / ________ **Patient's Blood Type (Required)**______________________________

Hospital / City____ Blood Supplier____

Indication(s) for Directed Donation: ____

Physician's name (print) ____ Physician's Telephone ____

Physician's signature ____ Date ____

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

My signature below attests that I have read the information given to me about directed donations and that I understand that blood donors selected by me are no safer than donations from other volunteers. I understand that blood from directed 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
- Unit is not acceptable by screening tests

Innovative Blood Resources cannot guarantee that directed units will be available. Blood donated for me is the property of the blood center. The blood center will take reasonable measures to deliver directed units to the hospital within a timely manner. If not compatible, they will be made available to other patients. 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 directed 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 (PLEASE PRINT)

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): ____

CONFIDENTIAL/PROPRIETARY: Distribution outside company with permission only.

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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) ______________________________________

____ ____________________
Transfusion Services Signature/Approval Date

____
Transfusion Services Printed Name

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 seven (7) working days prior to expected use.

IBR Physician Services Use Only

Physician Comments

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____ ____________________
IBR Physician Signature **Date**