



Innovative Blood Resources
737 Pelham Boulevard
Saint Paul, MN 55114
Fax: 651-332-7029
Email: IBR-MD.physicianorders@innovativeblood.org

Physicians Order Form for Directed Donations – Information & Instruction Sheet

Directed donations are appropriate for patients with a medically justifiable need for blood products requiring attributes not found or exceedingly rare in the standard blood bank inventory. These blood products are requested from the patient’s healthcare provider and must be approved by the hospital transfusion service before review and approval by the blood center medical director. They are medically justifiable due to the inability to supply compatible blood readily from the general donor base and may require screening and testing of family members with known ABO blood types compatible with the patient. **This service is available only to hospitals we provide blood products to.**

Importantly, blood donors who have received the SARS-CoV-2 mRNA vaccine do not pose a risk for the safety of the blood supply. Hence, this is not a medically justified request for a directed donation and impose arduous and costly logistical challenges for the blood center and the hospital. In addition, directed donations of platelets, plasma, and cryoprecipitate are logistically difficult and not offered as an option by our blood center.

Further,

- Mother-to-child directed donation poses an increased risk of transfusion-associated acute lung injury (TRALI).
- Male partner to female partner directed donation poses risk of hemolytic disease of the fetus and newborn (HDFN) and alloimmune thrombocytopenia to future children. Therefore, husbands or potential fathers, may not serve as directed donors for women of childbearing potential.
- Blood donation by a family member who is a potential future stem cell or solid organ transplant donor may cause the patient/recipient to develop red cell or HLA antibodies against that donor’s antigens.

Examples of medical indications for directed donations include:

Alloimmunization Risk

Rare Blood Type

IgA Deficiency

Instructions: Complete **all** parts of the form, front and back. After completing parts I – III the form can be emailed to IBR-MD.physicianorders@innovativeblood.org or faxed to **651-332-7029** for approval by the IBR Physician. Once approval has been received from the IBR Physician the donor(s) listed in Part II will be contacted to schedule appointments.

Note: Incomplete forms will not be accepted.

Questions of Concerns? Contact IBR-MD.physicianorders@innovativeblood.org



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

Please select the medical indication: Rare Blood Type Alloimmunization Risk IgA Deficiency
 Other _____ (requires approval by IBR Medical Director)

Indicate type and quantity of components: RBC (packed cells) Other (special approval required) _____

Number of units _____

Patient's 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. (Note: All units will be irradiated)

Date of expected use: ____ / ____ / ____

Patient's Blood Type (Required) _____

Hospital / City _____

Blood Supplier _____

Physician's Name (print) _____

Physician's Telephone _____

Physician's Signature _____ Date _____

Physician's Email _____

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

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. Depending on the blood center there will be additional fees incurred for directed donations that are added to the transfusion service's fees. These might not be covered by insurance.

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): _____

Signature of Patient's Physician _____

Forward to Hospital Blood Bank or Medical Director of Transfusion Services for completion of page 4



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PART III: TO BE FULLY COMPLETED BY HOSPITAL BLOOD BANK OR TRANSFUSION SERVICES

Patient: _____ Blood Type _____

Patient's Date of Birth: ____/____/____ Anticipated date of use: ____/____/____

Component Information:

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

- LEUKOREduced AS-1 RED CELL (CPD DOUBLE)
- LEUKOREduced CPDA-1 RED CELL (CPDA-1 DOUBLE)
- Pediatric bags attached
- Other (specify) _____

 Transfusion Services Medical Director or Designee Signature/Approval

 Date

 Transfusion Services Medical Director or Designee Printed Name

Submit completed form by fax to 651-332-7029 or by email to IBR-MD.physicianorders@innovativeblood.org

PART IV: TO BE COMPLETED BY IBR PHYSICIAN SERVICES ONLY

Approved _____

Not Approved _____

Physician Comments

IBR Physician Signature **Date**