

Special Donations Record

Instructions: Complete Part I and FAX to 816.277.0785 Therapeutic Services

Part I (to be completed by person ordering Special Donation)

Patient Information

First Name	MI	Last Name	Birthdate	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Address		City	State	Zip Code
For minor patients only: Parent or Guardian name(s):				
Home Phone			Alternate Phone	
Diagnosis/Surgery				
Hospital			Anticipated Date of Use (date blood will be available at transfusing facility)	

Physician's Order

Donation Type <input type="checkbox"/> Autologous and/or <input type="checkbox"/> Directed *If Directed Donor: Recipient's confirmed blood type _____ Confirmed by _____			Number of Units _____
Unit Type	<input type="checkbox"/> Red Blood Cells Leukocytes Reduced <input type="checkbox"/> FFP <input type="checkbox"/> Pediatric Quad/CPDA-1 <input type="checkbox"/> Granulocytes – Use Granulocyte Product Request (KC-FORM-1617) to order this product <i>*Platelet products are not available from directed or autologous donors</i>		
Unit Specifications for Directed Products:	Select One: <input type="checkbox"/> ABO Type Identical <input type="checkbox"/> ABO Type Compatible	Select as needed: <input type="checkbox"/> Anti-CMV Negative <input type="checkbox"/> Irradiated <input type="checkbox"/> Other (specify) _____	
Medical Indication(s) for Requesting Directed or Autologous donations:			

Ordering Physician Information

Physician Name	Phone	Fax	
Address	City	State	Zip Code
Physician Signature			Date

Part II (Medical Director Approval)

<input type="checkbox"/> Approved	<input type="checkbox"/> Not Approved	Med Dir signature/date:
Comments:		