University of Colorado Hospital
12401 E 17th Avenue
Leprino Building
Blood Donor Center Room # 145
Box A022

Physician Order for Autologous and Directed Donation
(Please circle Donation Type)

Patient (Recipient) addressograph (if available)

Today's Date_____

Patient Information: (Please complete if addressograph is unavailable)

Last Name	First Name	MR#	
Date of Birth	Social Security #	Clinic/Hospital Loc	ABO-Rh (if known)

Physician Order: **Ordering Physician_____ Pager_____**
(**Required**) (**Required**)

Type of Surgery / Diagnosis_____

Date of Surgery or Anticipated Transfusion_____ **Location: AOP _____ AIP _____**

Product(s) requested: Autologous Whole Blood____ Red Blood Cells___ Platelets____ Plasma_____

Note: All Autologous units are left as Whole Blood.

Number of Units Requested_____ Frequency of Transfusion (if applicable)_____

Number of Anticipated Directed Donors_____

Special Instructions:

Physician Signature (Required)_____Date_____

Please fax Orders to **720-848-1056**. For information call UCH Blood Donor Center **720-848-1230**

Blood Donor Center Comments:

Problem:_____
Spoke with:_____ Date: _____ Tech Initials: _____

Transfusion Service Medical Director (or Designee) Review:

Comments:

Autologous - Directed Donation Approved / Date_____