Rock River Valley BLOOD CENTER

PHYSICIAN REQUEST FOR DIRECTED DONATION

PATIENT INFORMATION: PLEASE PRINT & FILL OUT COMPLETELY. THIS INFORMATION IS NEEDED TO ENSURE PROPER LABELING & DELIVERY OF BLOOD.

PATIENT LAST NAME:_____ FIRST NAME:_____ MI:_____

DATE OF BIRTH: _____ AGE: _____ *(Unit(s) must test CMV Negative for all patients under 6 months old.)*

BLOOD TYPE: _____ GENDER: ☐ MALE ☐ FEMALE

ADDRESS: _____

CONTACT NUMBER(s):_____

PROCEDURE: _____

TRANSFUSION DATE:_____HOSPITAL:_____

HOSPITAL ADDRESS: _____

DIRECTED DONATION ORDER: TO BE COMPLETED AND SIGNED BY ORDERING MEDICAL PROFESSIONAL.

PLEASE NOTE: ALL DIRECTED UNITS WILL BE IRRADIATED AND LEUKOREDUCED.

BLOOD PRODUCT REQUESTED: ☐ RED BLOOD CELLS # UNITS: _____ ☐ PLATELETS #: _____
☐ OTHER: _____ #: _____

DOES YOUR PATIENT REQUIRE: CMV NEGATIVE? ☐ YES ☐ NO
ABO TYPE SPECIFIC? ☐ YES ☐ NO
ABO COMPATIBLE? ☐ YES ☐ NO

_____ _____
ORDERING MEDICAL PROFESSIONAL NAME (PLEASE PRINT) OFFICE STREET ADDRESS

_____ _____
ORDERING MEDICAL PROFESSIONAL SIGNATURE CITY STATE

_____ _____ _____
DATE OFFICE PHONE OFFICE FAX

Please complete this form and return to RRVBC Special Services Department via email or fax.
Email: specialservices@rrvbc.org Fax: 815-965-8756

Rock River Valley Blood Center 419 N. 6th Street, Rockford, Illinois 61107 Phone 815-965-8751

This space for RRVBC use only.

*Donor name:*_____ *Relationship:* _____ *Contact #:*_____

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Notes:

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