Diane Mortenson, RN, BS
Special Services Coordinator
Direct: 815-961-2340
E-mail: dmortenson@rrvbc.org

PHYSICIAN REQUEST FOR * DIRECTED * DONATION

Fill out form & fax to: 815-965-8756

PATIENT INFORMATION

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

PATIENT:LAST NAME______________________ FIRST NAME______________________ MI______

PATIENT ADDRESS: ____

CONTACT NUMBERS: ____

DATE OF BIRTH:______________ SEX: _____ ID NUMBER (SS#): ______________________

BLOOD TYPE: __________ PROCEDURE: ______________________________

TRANSFUSION DATE______________________HOSPITAL______________________________

HOSPITAL ADDRESS: ____

AGE: ________ *(If the patient is under 6 months old, the unit will automatically be CMV Neg & Leukoreduced)*

TO BE COMPLETED AND SIGNED BY THE ORDERING PHYSICIAN:

BLOOD PRODUCT REQUESTED: ☐ # _____RED BLOOD CELLS. ☐ #_____FRESH FROZEN PLASMA.

☐ # _____ PLATELETS ☐ # _____OTHER: ______________________

Does your patient require:

CMV Negative? ☐ Yes ☐ No

Irradiated Component? ☐ Yes ☐ No
(to prevent Graft vs. Host Disease)

ABO Type Specific? ☐ Yes ☐ No

Leukoreduced Component? ☐ Yes ☐ No
(to prevent Febrile non-Hemolytic Transfusion Reactions)

______________________________ ______________________________
ORDERING PHYSICIAN NAME (PLEASE PRINT) OFFICE ADDRESS

______________________________ ______________________________
ORDERING PHYSICIAN SIGNATURE

__________ ______________________ ______________________
DATE OFFICE PHONE OFFICE FAX

ROCK RIVER VALLEY BLOOD CENTER ROCKFORD, ILLINOIS