

Form #:APU-545.00

UNIVERSITY OF MICHIGAN HEALTH SYSTEM
BLOOD BANK AND TRANSFUSION SERVICE

Rev: 24 Aug 09

PHYSICIAN REQUEST FOR AUTOLOGOUS DONATION

Patient Information

Patient must have a UM Registration Number to allow tracking of donated units.

Patient's Name

Patient's Telephone Number

U of M Hospital Registration #

Number of Autologous Units Requested

Patient's Date of Birth

Projected Date of Surgery

Surgical Procedure

Physician's Order

I request that blood from this patient be collected, processed, and stored for subsequent replacement transfusion.

I understand that the number of units of blood to be drawn and the interval between donations will be determined by anticipated blood requirements as well as the patient's hematocrit and other clinical criteria.

I have explained the reason for this procedure to this patient and have considered the need for iron supplementation.

I understand that for patients less than 18 years of age, consent of a parent or guardian is required at the time of each donation.

Physician's Signature

Date

Physician's Name (Print)

U of M Doctor Number

Hospital Location (Clinic or Service)

Physician's Phone and/or Pager Number

Comments/Special Instructions: