COMMUNITY BLOOD SERVICES

970 LINWOOD AVE WEST PARAMUS, NJ 07652
SPECIAL DONOR SERVICES
Phone 201 444-3900 Fax 201-444-1885

Instructions for Physician Order Form for Autologous and Directed Blood Collection

1. Patient and Hospital Information Document patient's last name, first name, (no nicknames). Document patient's date of birth and social security number. If known, document patient's day and evening phone number. **REQUIRED INFORMATION**: *Diagnosis*: Document patient's diagnosis, date of surgery/transfusion and reason for transfusion. *Transfusing Hospital*: Document the complete name, the city and the state.

2. Blood Products Order
2a. Please indicate all products requested

Autologous Units Indicate number of units next to the section "Whole Blood". Document number of units if Cryoprecipitate Is required. *Proceed to 3 Ordering Physician Information.*

Directed Units Indicate Number of units next to "Packed Red Blood cells." If applicable, document the number of units next to "Platelets by Apheresis", or "Fresh Frozen Plasma", *Proceed to 2b*

2b Patient Type and Rh. *For Directed DonorPatient's Only*.
Document the patient's ABO and RH. If it is unknown, the patient must be typed. This section **MUST** be completed. Units for the patient cannot be released without this information.

2c Request for Additional Services *For Directed Donor Patients Only* Place a check in each box as per the physician's request. Unless ABO match is specifically ordered, **units that are ABO compatible will be sent**.

2d Can blood relatives donate for this patient Yes_____ No_____ **must be checked** on all Directed Donor requests.

3 Ordering Physician Information The following statement is included as per State of New Jersey Department of Health on all Autologous & Directed Physician's Order Forms. "*I have explained & advised this patient of the Autologous, homologous & directed donor transfusion options including potential risks." This is a State of New Jersey Requirement.* Final approval and acceptance of the Autologous donor is the responsibility of the attending medical physician and the Blood Center's Medical Director.

The Physician MUST sign this form; a stamped signature will NOT be accepted. This is as per NJ State Department of Health. **Any forms received that are incomplete or have a stamped signature will be returned to your office to be done over and may result in a delay or cancellation of the donation**. Please complete the rest of this section including the Physicians' printed name, date, address, city, state, zip code office number and fax number.

Mail or Fax completed and signed form before the first donation. Fax (201) 444-1885. Thank you for your cooperation and assistance.

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BERGEN COMMUNITY REGIONAL BLOOD CENTER
970 Linwood Ave West, Paramus, NJ 07653
(201) 444-3900 - FAX (201) 444-1885
ATTN: SPECIAL DONOR SERVICES

PHYSICIAN'S ORDER FORM FOR AUTOLOGOUS AND DIRECTED BLOOD COLLECTION

(1)Patient and Hospital Information

Patient's Full Legal Name(Last)_____First_____MI_____

Birthdate_____Social Security Number_____ Sex Male( ) Female( )

Daytime Phone Number_____Evening Phone Number_____

Diagnosis_____Date of Surgery/Transfusion_____

Reason for Transfusion and/or type of surgery_____

Transfusing Hospital(complete name)_____

City_____State_____Zip Code_____

(2) Blood Products Order

(2a) Please indicate all products requested.Specify number of Autologous and/or Directed units.

AUTOLOGOUS	# OF UNITS
Whole Blood	
Cryopecipitate for "fibrin gule"	

DIRECTED	# OF UNITS
Packed Red Blood Cells	
Platelets by Apheresis	
Fresh Frozen Plasma	
Fresh Frozen Plasma by Apheresis	
200cc ☐ 400cc ☐	

2b) Patient ABO/RH Type_____(Mandatory)

(2c) Request for Additional Services

( ) ABO Match ( ) CMV Negative
( ) Irradiate all products ( ) Leuko-reduced
( ) Pedi Pak Other_____

2d) Can blood relatives donate for this patient? YES_____ NO_____

(3) Ordering Physician Information

This physician's signature is a request for blood donation and not an indication of the donor's acceptability to donate. I have explained & advised this patient of the autologous, homologous & directed donor transfusion options including potential risks.

Physician's Signature_____Print Name_____Date_____

Address_____City_____State_____Zip Code_____

Office Phone Number_____Fax Number_____

Mail or fax completed and signed form before first donation. Fax to 201-444-1885 or mail to above address. **The Physician <u>MUST sign this form</u>, a stamped signature will <u>NOT</u> be accepted. This is as per NJ State Department of Health.**

For Blood Center use only. Do not write below this line.

FBP# _____Contact Person:_____Days_____

Evenings_____