TITLE:	Form, Directed Donor Order				
DEPARTMENT:	03-Special Donations	**REF #**	03-02-06		
FORM #:	03-F03	**FORM/VER:**	2	**PAGE:**	1 of 1

Directed Donor Order Form

Ref: 03-02-06

Appointments and Information: (650) 723-6667 / FAX: (650) 723-8155 / EMAIL: specialdonations@stanford.edu

This Form Must Be Completed in Full

Number and Type of Units Requested:		**FOR INTERNAL SD DEPT. USE ONLY:**
Packed Red Blood Cells		CPD/AS1
Plasma		
Platelets		
Other: _____		

Patient Name: _____ Date of Birth: _____
Last First MI

Medical Record Number: _____Phone: Day: _____ Eve: _____

Type of Procedure Scheduled: _____ ICD-Code: _____

☐ Surgery ☐ Transfusion Date: _____ Ongoing ☐

Location for Transfusion: ☐ SHC ☐ LPCH ☐ Other: _____

Patient's Blood Type **(Required):** _____

Please Attach Lab Result of ABO/Rh Typing

Special Requirements:

Is CMV Negative needed? ☐ YES ☐ NO

Note: *If CMV Negative is ordered and donor unit tests CMV positive,* ***unit will not be sent to hospital****. If unsure of patient's CMV requirement, please verify with hospital transfusion service* ***BEFORE*** *placing order.*

Physician/NP/PA Name (Please Print): _____

Physician/NP/PA Signature (Required): _____ **Date:** _____

Physician/NP/PA Phone (Required): _____ **Physician/NP/PA Fax (Required):** _____

Physician/NP/PA Address (Required): _____

FOR BLOOD CENTER USE ONLY
Comments:
Physician Contact Info. Verified by: _____ Date: _____