AUTOLOGOUS AND DIRECTED PRESCRIPTION ORDER

TO THE PHYSICIAN:					
	DIRECTED DONATION				
 A prescription is required for autologous collection Autologous donors must weigh at least eighty (80) lbs A minimum of: 7 days is required between autologous donations 14 days is required between the last autologous donation and the date of surgery (or anticipated date of use) Autologous donors with known HIV, HCV, HBV, WNV, HTLV, or T. Cruzi (Chagas) infections are not collected Autologous units that test confirmed positive or indeterminate for HIV, HCV, HBV, WNV, HTLV, or T. Cruzi (Chagas) virus are not released for transfusion Units that are to be frozen require a physician's prescription that includes a directive to freeze the product 		 A prescription is recommended: when the patient is less than two (2) years of age for CMV negative platelet donations Male donors are not eligible to donate for their female partner capable of and intending to have children It is recommended to allow 3 days between collection and the intended date of use for unit testing, product processing and transport except when the requested product will expire sooner 			
		Patient ABO/Rh (Directed only, if known)			
			ber		
PHYSICIAN AND HOSPITAL/TRANSFUSION FACILITY INFORMATION					
PRODUCT(S) REQUESTED (OneBlood provides RBCs, unless otherwise specified)					
		recipitate		Plasma	Platelets
Enter Number of ducts Requested >					
Other >					
SPECIAL CONSIDERATIONS (mark all requested special considerations)					
/ Irradiate				Freeze (Aut	tologous Only)
ther >					
Comments					
PHYSICIAN SIGNATURE (physician or authorized medical professional requesting collection)					
				Date	
ONEBLOOD PRESCRIPTION REVIEW AND RSA ENTRY					
All required RX requirements present AND entered in RSA				Badge ID	
All required RX requirements NOT present AND physician / donor contacted				Date	
	OGOUS DONATION d for autologous collection t weigh at least eighty (80) lbs ween autologous donations etween the last autologous don r anticipated date of use) known HIV, HCV, HBV, WNV, as are not collected st confirmed positive or indetern HTLV, or T. Cruzi (Chagas) viru en require a physician's prescri eeze the product ON SPITAL/TRANSFUSION FA STED (OneBlood provides R Red Blood Cells (RBCs) y Irra Ref Blood Cells (RBCs) RE (physician or authorized m IPTION REVIEW AND RSA requirements present AND enter	OGOUS DONATION d for autologous collection t weigh at least eighty (80) lbs ween autologous donations etween the last autologous donation and r anticipated date of use) known HIV, HCV, HBV, WNV, HTLV, or T. is are not collected st confirmed positive or indeterminate for HTLV, or T. Cruzi (Chagas) virus are not en require a physician's prescription that eeze the product ON Patien Name Patien SPITAL/TRANSFUSION FACILITY INI STED (OneBlood provides RBCs, unless RE (physician or authorized medical profes	OGOUS DONATION A prescription to weigh at least eighty (80) lbs ween autologous donations at the end of use) known HIV, HCV, HBV, WNV, HTLV, or T. s are not collected st confirmed positive or indeterminate for HTLV, or T. Cruzi (Chagas) virus are not eaze the product ON Patient First Name Patient ABO/Rh (Directed only, if known HIV, HTRANSFUSION FACILITY INFORMATION Conception that the ease the product Patient or Patient's Family Phone Numbers STED (OneBlood provides RBCs, unless otherwise spection for a numbers STED (OneBlood provides RBCs, unless otherwise spection for a numbers STED (OneBlood provides RBCs, unless otherwise spection for a numbers Trradiate Irradiate Irradiate	OGOUS DONATION I d for autologous collection + A prescription is re-when the patient -for CMV negative tween the last autologous donation and ranticipated date of use) • Male donors are no capable of and intered date of use) known HIV, HCV, HBV, WNV, HTLV, or T. • It is recommended intended date of us transport except with the east end collected en require a physician's prescription that eeze the product • Patient First Name ON Patient ABO/Rh (Directed only, if known) Patient ABO/Rh (Directed only, if known) Patient or Patient's Family Phone Number SPITAL/TRANSFUSION FACILITY INFORMATION Hospital/Transfusion Facility Name & Address SPITAL/TRANSFUSION FACILITY INFORMATION Hospital/Transfusion Facility Name & Address STED (OneBlood provides RBCs, unless otherwise specified) Red Blood Cells (RBCs) Cryoprecipitate ATIONS (mark all requested special considerations) Irradiate Irradiate RE (physician or authorized medical professional requesting collect Irradiate Irradiate IPTION REVIEW AND RSA ENTRY requirements present AND entered in RSA Irradiate	OGOUS DONATION DIRECTED DONA d for autologous collection • A prescription is recommended: tweigh at least eighty (80) lbs • A prescription is recommended: ween autologous donations • A prescription is recommended: autoingue date of use) • Male donors are not eligible to donate for known HIV, HCV, HBV, WNV, HTLV, or T. • Male donors are not eligible to donate for sare not collected • It is recommended to allow 3 days betwee intended date of use for unit testing, pro eze the product • Male donors are not eligible to donate for own HIV, HCV, HBV, WNV, HTLV, or T. • It is recommended to allow 3 days betwee intended date of use for unit testing, pro eare the product • Male donors are not eligible to donate for own HIV, HCV, HBV, WNV, HTLV, or T. • Male donors are not eligible to donate for own HIV, HCV, HBV, WNV, HTLV, or T. • Male donors are not eligible to donate for own HIV, HCV, HBV, WNV, HTLV, or T. • Male donors are not eligible to donate for own HIV, HCV, HBV, WNV, HTLV, or T. • Male donors are not eligible to donate for own equire a physician's prescription that • Patient First wame Patient or Patient's Family Phone Number PITLL/TRANSFUSION FACILITY INFORMATION • Patient or Patie

