American Red Cross
Biomedical Services
Washington, DC 20006

Special Collection Order
Autologous & Directed

GC&P Region
4700 Mount Hope Drive
Baltimore, MD 21215p

Ⓐ Patient Information Record

Last Name	Suffix (Jr.)	First Name	MI	DOB
Address	City	State	Zip Code	Gender M ☐ F ☐
Primary Phone	Secondary Phone		E-mail	
Language	ID		ID Type	

Ⓑ Physician's Order

Donation Type: Autologous ☐ Directed ☐

Unit Type / Number of Units:

- Packed Red Blood Cells ☐ _____
- Whole Blood ☐ _____
- Apheresis ☐ _____ _____
- Other ☐ _____ _____
- Other ☐

Test for CMV ▶ Yes ☐ | Leuko-reduce ▶ Yes ☐ | Irradiate ▶ Yes ☐

Patient Recruited Directed Donor List (provide name)
Units from blood relatives will be irradiated unless specified otherwise

Ⓒ Physician's Preassessment of Autologous Donor

Please Check for Past or Present Medical Conditions:

Aortic Stenosis ☐ Pulmonary Disease ☐ Strokes / TIA ☐ Currently Pregnant ☐
Arrhythmia ☐ Bacteremia / Infection ☐ Seizures ☐ Current Anticoagulant Therapy ☐
Weight: _____ lbs

Cardiac / Cardiovascular Disease ☐ ▶ Explain _____
Cardiologist/Primary Physician Must Complete Section Ⓔ if Present

Restriction of Physical Activity/Disability ☐ Wheelchair ☐ Other ☐ ▶ Explain _____

Please list current medications _____

Ⓓ Ordering Physician's Information

Physician Name		Phone:	Fax:
Office Contact	Diagnosis / Surgical Procedure		**Transfusion Date**
Transfusion Service / Hospital		City	State
Physician Signature:		Date:	

Ⓔ Medical Clearance — To Be Completed by Cardiologist or Primary Physician

Cardiologist/Primary Physician Name	Phone:	Fax:

Yes ☐ ▶ It is my medical judgement that the above patient has no contraindications to give his/her own blood for autologous transfusion. The patient may donate at an American Red Cross site without a physician present.

No ☐ ▶ It is my medical judgement that the above patient should not donate autologous blood.

Physician Signature: Date:

Ⓕ For Red Cross Use Only

Assessment and Evaluation of Section C Indicates Medical Clearance is Required: Yes ☐ No ☐ Signature: Date:

Medical Clearance Received by (Init/ID) Date:

Sections A, B, and D Verified by (Init/ID) Date: