uchealth

Patient Label

# Physician Order of Autologous & Directed Donation for University of Colorado Hospital

**Today's Date**_____

**Patient Information:** (Please complete if label is unavailable)

Last Name First Name MR#

Date of Birth Social Security # Clinic/Hospital Loc. ABO/Rh (if known)

**Ordering Physician**_____ **Pager**_____
(**Required**) (**Required**)

Type of Surgery / Diagnosis_____

Date of Surgery or Anticipated Transfusion_____ **Location:** AOP _____ AIP _____

Type of Donation: ☐Autologous ☐Directed

Products requested (check all that apply):

☐Autologous Whole Blood ☐Red Blood Cells ☐Platelets ☐Plasma

**Note: All Autologous units are left as Whole Blood.**

Number of Units Requested_____ Frequency of Transfusion (if applicable) _____

Number of Anticipated Directed Donors: _____

Names & Phone Numbers of Potential Directed Donors:

Name: _____ Phone: _____

Name: _____ Phone: _____

Special Instructions:

**Physician Signature (Required)** _____**Date**_____

Please fax orders to **720-848-4407**. For information call UCH Transfusion Services **720-848-4444**

**Blood Donor Center Comments:**

Problem: _____

Spoke with: _____ Date: _____ Tech Initials: _____

**Transfusion Service Medical Director (or Designee) Review:**

Comments:

Autologous - Directed Donation Approved / Date_____