Clear Fields

Request for Autologous Collections

LifeSouth Community Blood Centers

Submit requests no later than 21 days prior to the surgery date. The Medical Office must approve requests prior to patient collection.

Section A: Patient Information

Last Name	First Name	Middle Name	Sex	SSN	MR# (if applicable)

Address	City	State	Zip	Home Phone	Alternate Phone

Blood Type	Date of Birth [1]	Hospital	Date of Surgery

Surgical Procedure:

☐ Bilateral Hip/Knee ☐ Spine, multiple levels ☐ Redo hip/knee

☐ Redo cardiac surgery ☐ Other, please describe:

Patient Diagnosis:

List all medications prescribed for this patient:

Please check any past or present medical conditions that apply to this patient:

☐ Cardiac/Cardiovascular Disease* ☐ Arrhythmia* ☐ Pulmonary Disease

☐ Stroke* ☐ Current Anticoagulant Therapy* ☐ Seizures

☐ Other (list all other conditions):

**A written cardiac release is required for these patients. Please provide the name of the patient's cardiologist/primary physician. Please attach written approval from the listed physician for autologous blood collection.*

Cardiologist/Primary Physician Name: _____ Phone: _____

Section B: Blood Components Requested

Check one: ☐ Packed Cells ☐ Other	Number needed: ☐ 1 ☐ 2

Section C: Requesting Physician Signature

Signature, MD:	Date:	
Physician (printed name):	Phone:	Fax:
Address:		

Section D: Blood Center Medical Office Decision

Name of Medical Director (or designee):

☐ APPROVED for _____ units of Whole Blood --> Packed cells +/- FFP ☐ NOT APPROVED

Signature:	Date:

Comments:

Fax completed form to the Medical Office at (888) 286-0179.

1 Autologous donations are limited to patients from age 18 through age 65.

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Form Version History

Effective Date	Significant Changes
23 Jun 2023	Added the **Sex** field.

***Note**: Technical Communications began publishing version history details for forms created or modified on or after 30 Jun 2015. Contact Technical Communications for history details on prior existing versions.*