



The Children's Hospital

# Physician Referral for Autologous Blood Products

**This form must be completed and signed by the patient's physician.**

Please return the completed form to the Blood Donor Center:

Tube 416, Campus Box 605, Phone: (720) 777-5398, Email: [Donate4Kids@tchden.org](mailto:Donate4Kids@tchden.org)

**Required Patient Information:**

Name \_\_\_\_\_ MR# \_\_\_\_\_

DOB \_\_\_\_\_ Age \_\_\_\_\_ Weight \_\_\_\_\_

Diagnosis \_\_\_\_\_ Surgery Date \_\_\_\_\_

Parent(s) Contact \_\_\_\_\_ Phone \_\_\_\_\_

Contact \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Is the patient approved by physician for autologous donation? Check One: YES \_\_\_ NO \_\_\_

Number of whole blood units to be drawn from patient \_\_\_\_\_

Comments \_\_\_\_\_

Physician Signature \_\_\_\_\_

Printed Name of Physician \_\_\_\_\_

Phone \_\_\_\_\_

Please check here if interpreter services will be needed \_\_\_ Language \_\_\_\_\_

**FOR DONOR SERVICE USE ONLY**

Date Received \_\_\_\_\_

**Autologous Consult for Medical Director or Designee Approval:**

1. Iron supplement YES \_\_\_ NO \_\_\_

2. Restrictions/Limitations \_\_\_\_\_

3. Previous surgery \_\_\_\_\_

4. Physicians \_\_\_\_\_

5. To use local anesthetic (EMLA) YES \_\_\_ NO \_\_\_

6. Approved for AUTO Donation YES \_\_\_ NO \_\_\_

Medical Director or Designee Signature \_\_\_\_\_ Date \_\_\_\_\_

Assigned Phlebotomist: \_\_\_\_\_ Date pamphlet/information sent to family \_\_\_\_\_

Donation Schedule \_\_\_\_\_

\_\_\_\_\_