Children's Hospital Colorado

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@childrenscolorado.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 ____

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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 YES ____ NO____

Medical Director or Designee Signature ____________________ Date ______________

Approved for AUTO Donation YES ____ NO____

Donation Schedule ____________ ____________ ____________

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