American Red Cross
Biomedical Services
Washington, DC 20006

Special Scheduling
Phone: 800-634-9069
Fax: 800-886-7024

Special Collections Order
Autologous and Directed

A Patient Information Record

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

B Physician's Order

Donation Type	Autologous ☐	Directed ☐	Number of Units	Patient Recruited Compatible Directed Donors List (provide names) Units from blood relatives will be irradiated unless specified otherwise
Unit type	Packed Red Blood Cells ☐		________	
	Whole Blood NA		________	
	Apheresis ☐		________	
	Other ☐	________	________	
	Other ☐			
Test for CMV: Yes ☐	Leuko-reduce: Yes ☒	Irradiate: Yes ☐		

C Pre-assessment of Autologous Donor

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 E if present

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

Please list current medications ________________________________

D Ordering Physician's Information

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

E Medical Clearance To Be Completed by Cardiologist or Primary Physician

Cardiologist/Primary Physician Name	Phone:	Fax:
Yes ☐ It is my medical judgment 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 judgment that the above patient should not donate autologous blood.		
Physician Signature:	Date:	

F For Red Cross Use Only

F For Red Cross Use Only	Case ID	
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:	CAPSTAR Verified by (Init/ID)	