



ATTENTION

Autologous/Designated
Donor

Doctor's Request
for Autologous/Designated
Donation

Patient Information

Surname _____

Full First Names _____

Tel No: (H) _____ Date of Birth DD / MM / YEAR

(W) _____

(CELL) _____ E-mail _____

Date of Operation DD / MM / YEAR Time _____

Hospital _____

Anaesthetist _____

Products available for Transfusion

Products	Number of Units
<input type="checkbox"/> Whole Blood	_____ → <input type="checkbox"/>
<input type="checkbox"/> Red Cell Concentrate	_____ → <input type="checkbox"/>
<input type="checkbox"/> Infant Red Cells	_____ → <input type="checkbox"/>
<input type="checkbox"/> Leucocyte Reduced Whole Blood	_____ → <input type="checkbox"/>
<input type="checkbox"/> Leucocyte Reduced Red Cells	_____ → <input type="checkbox"/>
<input type="checkbox"/> Leucocyte Reduced Paediatric Red Cells	_____ → <input type="checkbox"/>
<input type="checkbox"/> Leucocyte Reduced Paediatric Whole Blood	_____ → <input type="checkbox"/>
<input type="checkbox"/> Fresh Frozen Plasma	_____ → <input type="checkbox"/>
<input type="checkbox"/> Platelets	_____ → <input type="checkbox"/>
<input type="checkbox"/> Other	_____ → <input type="checkbox"/>
_____	_____ → <input type="checkbox"/>
_____	_____ → <input type="checkbox"/>
_____	_____ → <input type="checkbox"/>

NB! PLEASE NOTE:
These units will be labelled with distinctive Autologous/Designated labels. Please ensure that the units you are transfusing are the units which have been specifically donated for this patient.

Leucocyte reduced YES NO

Medical History of Recipient

Please indicate

Cancer Cardiac Disease Diabetes Epilepsy

Respiratory Disorder Rheumatic Fever

Other (please state) _____

Current Medications _____

Doctor's Name _____ Practice No. _____

Address _____

Tel No _____

Fax No _____ Doctor's Signature _____

E-mail _____

Please hand completed request form to the patient or fax to 021 531 3335.