Special Donations Record

Instructions: Complete Part I and FAX to 816.277.0785 Therapeutic Services

Part I (to be completed by person ordering Special Donation)

Patient Information

First Name	MI	Last Name	Birthdate	Gender ☐ M ☐ F
Address		City	State	Zip Code
For minor patients only: Parent or Guardian name(s):				
Home Phone		Alternate Phone		
Diagnosis/Surgery				
Hospital		Anticipated Date of Use (date blood will be available at transfusing facility)		

Physician's Order

Donation Type ☐ Autologous and/or ☐ Directed ***If Directed Donor:** Recipient's confirmed blood type_____ Confirmed by _____	Number of Units _____
Unit Type ☐ Red Blood Cells Leukocytes Reduced ☐ FFP ☐ Pediatric Quad/CPDA-1 ☐ Granulocytes – Use **Granulocyte Product Request** (**KC-FORM-1617**) to order this product ****Platelet products are not available from directed or autologous donors***	

Unit Specifications for Directed Products:	**Select One:** ☐ ABO Type Identical ☐ ABO Type Compatible	**Select as needed:** ☐ Anti-CMV Negative ☐ Irradiated ☐ Other (specify)_____

Medical Indication(s) for Requesting Directed or Autologous donations:

Ordering Physician Information

Physician Name	Phone		Fax
Address	City	State	Zip Code
Physician Signature		Date	

Part II (Medical Director Approval)

☐ Approved ☐ Not Approved Med Dir signature/date:
Comments: