Autologous Collections Request

Procedure Eligibility

- Hemoglobin of 12.0g/dl or higher.
- Patients must meet weight requirement of 114 lbs.
  - Any weight <114 lbs. must be approved by the blood bank MD.
- Antibiotic therapy completed.
- No breathing problems requiring oxygen, severe cardiovascular disease, e.g. critical aortic stenosis, severe coronary artery disease, unstable angina or angina at rest.

General Information

- Whole Blood collections must be at least 3 days apart and a minimum of **14 days prior** to surgery.
- 2 RBC automated collections must be done at least 21 days prior to surgery.
- Blood is screened for selected infectious disease markers – both the ordering physician and the patient will be notified of any significant test results.
- On rare occasions, please be aware that a collection may not be completed or a collected unit may not be available for transfusion.
- A special handling fee will be charged. Payment is required before the procedure (with some exceptions).
- Fax Autologous request to: **619-297-4064**
- The patient must do the following:
  - Schedule an appointment with the Special Procedures Scheduling at **1-877-659-2001**
  - Maintain regular eating habits and drink plenty of fluids several days before.
- Patients **must** bring a photo ID.

Patient Information (ALL fields mandatory)

Last Name	First (Legal) Name	Middle Initial	Suffix	Gender ☐ M ☐ F	Birth Date (mm-dd-yy)

Parent/Guardian Name (If patient is a minor)	Address	City	State	Zip

Primary Language	Weight	Phone Number ( ) ☐Home ☐Cell ☐Work
		Alternate Phone Number ( ) ☐Home ☐Cell ☐Work

Surgery Information

Date of Transfusion /Surgery	Transfusing Facility/Hospital
ICD-9 / ICD-10 Code	**Diagnosis**

Components Ordered	Number of Units
☐ Red Blood Cells	
☐ Plasma	
☐ Other:	

Physician's Pre-Assessment of Patient: *Please check for past or present medical conditions.*

☐ Angina ☐ Aortic / Subaortic Stenosis ☐ Cardiomyopathy ☐ Cardiovascular Disease	☐ CHF- Symptomatic ☐ Recent MI (<6 months ago) ☐ Recent Stent placement (<6 months ago) ☐ Seizures (Uncontrolled)	☐ Shortness of Breath ☐ Strokes/TIA ☐ Other:
Is patient capable of transferring to donation bed independently? ☐ Yes ☐ No	**Additional Comments:**	

Physician Information (ALL Fields Mandatory)

Physician Name (Please Print)	Office Phone Number ( )	Fax Number ( )
Office Email Address	**Address**	

In my opinion, there are no medical findings that would preclude this patient from completing an Autologous procedure. I understand that the patient eligibility is subject to the blood bank MD approval.

Physician Signature **Date**

Blood Bank use only:

Insurance: ☐ Medicare ☐ Medi-Cal ☐ CMS ☐ Tri-Care ☐ Worker Comp ☐ Other:			
Entered into Safe Trace: (Staff ID)	**Date:**	**Verified in Safe Trace: (Staff ID)**	**Date:**