REQUEST FOR AUTOLOGOUS DONATION

OBI Special Donation Coordinator Fax #: 405-297-5598
For questions please call (405) 297-5597

Patient Personal Information					
Name:					
DOB		Gender	☐ Male ☐ Female		
Address:					
City:		State:		Zip Code:	
Phone #:	( )				

Donation Request Information			
Type of Surgery or Diagnosis			
Name of Transfusion Facility			
Date of Transfusion			
Transfusion Facility City and State			
Number **and** Type of units ordered	☐ Leuko-Reduced RBC: _____ ☐ Plasma: _____ ☐ Platelets: _____ ☐ Other: _____		
Patient has sickle cell trait (mark one)	☐ **Positive** ☐ **Negative** ☐ **Unknown**		
Require CPD Solution (Anticoagulant Citrate Phosphate Dextrose)	☐ **Yes** ☐ **No**		
Ordering Medical Care Provider's Office Phone	( )	Office Fax	( )
Ordering Medical Care Provider's **Printed Name**			
Ordering Medical Care Provider's **Signature**			

ABI/OBI/TBI/CMBC USE ONLY

Date Order Received:		Patient BECS ID:			
Date Order Entered in BECS:		Date Order Expires:		Tech ID (Order Entry):	
Comments:					
Review:		**Date Reviewed:**			

Allogeneic Deferral Review					
Deferral Review Date:		Deferral Code(s) Posted:	☐ N/A	Tech ID (Deferral Review):	

Facility Name: Sylvan N. Goldman Oklahoma Blood Institute 1001 N. Lincoln, Oklahoma City, Oklahoma 73104. The official copy of blood bank documentation is the electronic copy on file with the local area network. The official copy of records created from forms is paper unless designated otherwise.

Print Date:

Apply Location sticker here
OR
Insert Location code_____