# 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 |
| Home Phone | | Alternate Phone | | |
| Diagnosis/Surgery | | | | |
| Hospital | | Surgery/Transfusion date | | |

**Physician's Order**

| | |
|---|---|
| **Donation Type** ☐ Autologous and/or ☐ Directed<br>*If Directed Donor:<br>Recipient's confirmed blood type___________ Confirmed by ____________ | Number of Units<br>_____________ |
| **Unit Type** ☐ Red Blood Cells Leukocytes Reduced ☐ FFP ☐ Pediatric Quad/CPDA-1<br>☐ Granulocytes – Use **Granulocyte Product Request** (**KC-FORM-1617**) to order this product | |
| **Unit Specifications** ☐ ABO Type Identical ☐ Anti-CMV Negative ☐ Irradiated<br>☐ ABO Type Compatible ☐ Other____________________________ | |

**Ordering Physician Information**

| Physician Name | | Phone | Fax |
|---|---|---|---|
| Address | City | State | Zip Code |
| Physician Signature | | | |
| Nurse/Coordinator | | | |

**Part II (to be completed by Therapeutic Services Staff)**

| Name | | Birthdate |
|---|---|---|
| Medical Doctor | | Phone |
| Donation Site | Donation Date(s) | |
| Completed by | | Date |