REQUEST FOR AUTOLOGOUS BLOOD COLLECTION AND TRANSFUSION

REASON FOR ISSUE: New National document.

Full And Accurate Completion Of This Form Is Essential

Patient Details

Family Name	Given Names	
Date of Birth	Gender	NHI
Day Time Phone Number	Fax Number	Surgeon
Postal Address		
Diagnosis/Surgical Procedure/Other conditions, e.g. Clinical Problems, medications		
Blood is required at: (time) on (date) at (place) Hospital		
Number of Units Required (maximum 4)		

Doctor's Declaration

- In my opinion, the patient is fit to have collected from him/her the number of blood units which have been requested.
- I agree to prescribe supplemental iron therapy for this patient.
- I give permission to the NZBS Medical Officer to vary the number of blood units collected, depending on the health status of the patient.

Doctor's Name	Phone/Fax Numbers
Doctor's Signature	Date
Doctor's Address	

Patient Consent

- I agree to meet the costs of collection, processing, storage and distribution of my blood.
- The benefits, risks and alternatives for an autologous blood collection and transfusion have been explained to me and I agree to participate.
- I consent to my blood being tested for blood groups and evidence of some infections, including HIV, Hepatitis B & C, Syphilis, HTLV and any other test found necessary.
- I understand I will be informed if any important abnormalities are found and details of the test results will be sent to my doctor.
- I understand that it may not be possible to return to me all or any of the units which I have had collected.
- I understand that it may be necessary to supplement my own blood requirements with blood or blood products obtained from volunteer donors of the Blood Service and I agree to this.
- In the event that my blood is not required for myself I understand that it will not enter the donor pool but that it may be used for laboratory or teaching purposes.

Full Name	
Signature	Date

Retain A Copy Of This Form In The Patient's Notes

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Clinical Assessment

Medical/Surgical History	
Medication(s)	
Pulse	BP
Meets DSR Criteria: Yes/No	
Accepted/Not Accepted for Autologous Donation	
Reason for Non Acceptance	
Assessor's Signature	Date
MO Signature (if Required)	Date

Record of Donations

Date	Donation Number	Hb	Patient's Signature	Phlebotomist's Signature	Comments