



ST. LUKE'S®
EPISCOPAL
HOSPITAL

REQUEST FOR AUTOLOGOUS BLOOD DONATION

St. Luke's Episcopal Hospital Blood Donor Center
6720 Bertner Avenue, MC 4-265
Houston, Texas 77030
Phone: 832-355-4483
Fax: 832-355-6837

I request that the following patient have blood collected and stored for autologous transfusion if warranted. In my opinion, withdrawal of the number of units indicated will not be detrimental to my patient's well being. I HAVE DISCUSSED THIS PROCEDURE AND ITS PURPOSE WITH MY PATIENT AND THE PATIENT IS IN AGREEMENT.

Patient's name _____ DOB _____

St. Luke's Medical Record Number _____ Insurance Pre-cert # _____

HBOC Account and Type _____ Insurance Co. _____

Diagnosis _____

Contemplated Surgery _____

Date of Surgery _____

Signature of physician/Date

Print

Physician's Name: _____ Phone: _____ Fax: _____

AUTOLOGOUS BLOOD ORDERS:

AUTOLOGOUS WHOLE BLOOD _____ (indicate number of units to be collected)

DONOR CENTER USE:

Unit Number	Date of Collection	Hematocrit