INLAND NORTHWEST BLOOD CENTER
800-423-0151 ● www.inbcsaves.org

PHYSICIAN'S REQUEST FOR DIRECTED DONATION

Patient Information:

Name: _____ Blood Type: _____ Date of Birth:_____
(Last, First)

Address: _____
(Street, City, State and Zip Code)

Telephone Number: Home (_____)_____ Work (_____)_____

Diagnosis/Surgical Procedure: _____

Emergency Contact: Name: _____ Phone: (_____)_____

Surgical/Transfusion Procedure:

Scheduled at: _____ hospital facility on _____ date. ❑ **Before 9:00 a.m.**
❑ **After 9:00 a.m.**

I am requesting the Inland Northwest Blood Center collect _____ units of Directed Donation blood and/or to provide the following blood components.

❑ Adult RBC ❑ Pediatric RBC ❑ Pediatric FFP

❑ Fresh Frozen Plasma ❑ Platelets

A list of suggested donors appears on the reverse side.

Physician Information:

Ordering Physician Name: _____

Phone: (_____)_____ Fax: (_____)_____Email:_____

Office Address: _____
(Street, City, State and Zip Code)

_____ _____
Ordering Physician Signature Date

PLEASE FAX THE COMPLETED FORM TO (509) 232-4526

INBC Use Only:

❑ Directed Donor ❑ Dedicated Donor (Prior Approval) _____
INBC Authorized Signer

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I agree to receive donated units from the acceptable donors specified by me. **In the event that I need additional units of blood, I agree to accept blood from the regular blood supply. I understand that not all directed donations will be compatible with my blood. I understand that not all donated units will qualify as acceptable units due to abnormal testing results or incompatibility.**

I have been advised by my physician about my anticipated surgical or other care including the material risks of the care, the alternative forms of treatment and/or non-treatment. The Directed Donation process and the use of that blood in my care are decisions made by me and my physician and I release the INLAND NORTHWEST BLOOD CENTER (INBC) and its agents from all claims relating to or arising out of either the decision to use blood or blood products provided by INBC.

I authorize INBC and its agents to contact my physician to obtain information necessary for processing the blood donations. I also authorize INBC to provide my physician with all information generated from the compatibility testing of my blood.

____ ____
Patient's Signature Date Physician's Signature Date

Suggested Donor Name, Address and Telephone Number

Name: ____
Address: ______________________________________
Phone: (________)________________________________
Blood Donor at INBC: ☐ Yes ☐ No ☐ ID Verified

Name: ____
Address: ______________________________________
Phone: (________)________________________________
Blood Donor at INBC: ☐ Yes ☐ No ☐ ID Verified

Name: ____
Address: ______________________________________
Phone: (________)________________________________
Blood Donor at INBC: ☐ Yes ☐ No ☐ ID Verified

Name: ____
Address: ______________________________________
Phone: (________)________________________________
Blood Donor at INBC: ☐ Yes ☐ No ☐ ID Verified

Name: ____
Address: ______________________________________
Phone: (________)________________________________
Blood Donor at INBC: ☐ Yes ☐ No ☐ ID Verified

Name: ____
Address: ______________________________________
Phone: (________)________________________________
Blood Donor at INBC: ☐ Yes ☐ No ☐ ID Verified

Name: ____
Address: ______________________________________
Phone: (________)________________________________
Blood Donor at INBC: ☐ Yes ☐ No ☐ ID Verified

Name: ____
Address: ______________________________________
Phone: (________)________________________________
Blood Donor at INBC: ☐ Yes ☐ No ☐ ID Verified