



A member of the
St. Joseph Hoag Health alliance

Autologous Collections Request

Procedure Eligibility

- Hematocrit of 36% or higher.
- Patients must meet weight requirement of 114 lbs.
 - Any weight <114 lbs. must be approved by the blood bank CMO or designee.
- Antibiotic therapy completed.
- No breathing problems requiring oxygen, severe cardiovascular disease, e.g., critical aortic stenosis, severe coronary artery disease, unstable angina or angina at rest.

General Information

- Whole Blood collections must be at least 3 days apart and a minimum of **14 days prior** to surgery.
- 2 RBC automated collections must be done at least **21 days prior** to surgery.
- Blood is screened for selected infectious disease markers; the ordering physician and patient will be notified of any significant test results.
- On rare occasions, please be aware a collection may not be completed or a collected unit may not be available for transfusion.
- A special handling fee will be charged. Payment is required before the procedure (with some exceptions).
- Fax Autologous Collections Request to **(619) 297- 4064**.
- The patient must do the following:
 - Schedule an appointment with the Special Procedures Scheduling at **(877) 659-2001**.
 - Maintain regular eating habits and drink plenty of fluids several days before.
- Patients **must** bring a photo ID.

Patient Information (ALL fields mandatory)

Last Name	First (Legal) Name	Middle Initial	Suffix	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate (mm-dd-yyyy)
Name of Parent/Legally Authorized Representative		Address		City	State Zip
State Relationship:					
Primary Language	Weight	Mobile Phone # ()		Alternate Phone # () <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other	

Surgery Information

Date of Transfusion /Surgery	Transfusing Facility/Hospital	Components Ordered	Number of Units
ICD Code	Diagnosis	<input type="checkbox"/> Red Blood Cells	
		<input type="checkbox"/> Plasma	
		<input type="checkbox"/> Other:	

Physician's Pre-Assessment of Patient: *Please check for past or present medical conditions.*

<input type="checkbox"/> Angina <input type="checkbox"/> Aortic / Subaortic Stenosis <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> CHF - Symptomatic <input type="checkbox"/> Recent MI (<6 months ago) <input type="checkbox"/> Recent Stent Placement (<6 months ago) <input type="checkbox"/> Seizures (Uncontrolled)	<input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Strokes/TIA <input type="checkbox"/> Other:
Is patient capable of transferring to donation bed independently? <input type="checkbox"/> Yes <input type="checkbox"/> No	Additional Comments:	

Physician Information (ALL Fields Mandatory)

Physician Name (Please Print)	Office Phone # ()	Fax # ()
Office Email Address	Address	
<i>In my opinion, there are no medical findings that would preclude this patient from completing an Autologous procedure. I understand patient eligibility is subject to approval of the blood bank CMO or designee.</i>		
Physician Signature	Date	

Blood Bank use only:

Insurance: <input type="checkbox"/> Medicare <input type="checkbox"/> Medi-Cal <input type="checkbox"/> CMS <input type="checkbox"/> Tri-Care <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Other:			
Entered into SafeTrace: (Staff ID)	Date:	Verified in SafeTrace: (Staff ID)	Date: