

Mercy Hospital St. Louis Blood Donor Services

DIRECTED DONATION REQUEST

Pat	tient Name:	MRN:
Ad	ldress:	Patient ID:
		Request ID:
Bir	thdate:/ Phone: ()	
Ph	ysician:	
Da	te of Transfusion/Surgery:	
Loc	cation: ☐ Mercy Hospital St. Louis ☐ Mercy Hospital Washington ☐ Other:	
NS	TRUCTIONS TO THE PATIENT:	
	1. Complete the above information; use the name AS IT APPEARS ON YOU	IR INSURANCE CARD.
	2. Sign and date the form below.	
	3. Have a witness, age 18 or older, sign and date the form below your signature.	
	4. Ask your donors to schedule their own appointments by calling 314-251-4483 or toll free 866-373-6667 Monday – Friday.	
	5. Return this request form to Blood Donor Services prior to the first schedu	led donation.
	6. Completed forms may be sent by FAX, 314-251-7454.	
My is r	ereby request that the Mercy Hospital St. Louis (MHSTL) Blood Donor Services y signature below signifies that I have read and understand the information abound evidence that blood from donors selected by me is safer than blood from regularity PATIENT INFORMATION sheet, I understand that:	ut Directed Donation. I understand that there
1.	All donors requesting to donate for me will be directed donors, and these products will be held for me only if they are ABO/Rh compatible.	
2.	2. Some directed donor units may not be suitable for transfusion.	
3.	3. MHSTL does not offer nor imply warranty that directed donations decrease the generally recognized risks of transfusion, e.g., reactions, infections, etc.	
4.	MHSTL Blood Bank assumes no responsibility if an insufficient amount of directed donations has been collected, or if accident or other mishap renders the donated unit unusable.	
5.	The donor's medical history and all results remain strictly confidential.	
6.	Patients with ongoing transfusion needs must notify Blood Donor Services.	
7.	Directed Donations Request form(s) for patients with ongoing transfusion needs will be held in current file for 12 months. After that time, a new Directed Donation Request form will be required.	
PA [·]	TIENT SIGNATURE: (Parent or guardian must sign for patient, if patient is under age 18)	DATE:
WI	ITNESS SIGNATURE: (Required) Forms submitted without a witness will not be accepted.	DATE: