

## Designated Donor Request

<b>THE FOLLOWING INFORMATION MUST BE PROVIDED BY THE INTENDED RECIPIENT (or guardian) BEFORE THE DONOR CAN BE DRAWN. PLEASE PRINT</b>	
Patient Name	Hospital Number
Address	Surgeon/Physician
City                      State	Surgical procedure/reason for Transfusion
Date of Birth                      Room Number	Exact Date of Surgery/Transfusion

I request that the Eileen Murphree McMillin Blood Center of The Methodist Hospital draw one (1) unit of blood from the person named below and reserve the red blood cell unit from that donation for my exclusive use for a period of fourteen (14) days should I require a transfusion.

\_\_\_\_\_

Please Print Your Donor's Name

I understand that this blood unit is no safer than random units of blood from the community blood supply and that it must be donated no sooner than 2 weeks prior to use or no later than 2 working days prior to use. **The blood will not be available for my use unless the donor passes all routine screening and laboratory testing.** I also understand that while the same donation criteria, screening procedures, and tests will be used for my designated donor as for community donors, no amount of testing or screening will provide absolute safety from any transfusion-transmitted disease. If the donated unit is, for any reason, incompatible or unacceptable, it will not be reserved. If I require more blood than anticipated, the community supply is available. **\*No guarantees have been made to me about the availability or safety of this designated component.**

\_\_\_\_\_

Patient's Signature

**IMPORTANT:** Patient's original signature is required on each sheet. If the patient is unable to sign, next of kin must sign.

**NOTE:** There will be a storage fee per unit applied to the patient's account upon donation of the unit whether or not it is transfused.

<b>TO BE COMPLETED BY DONOR – (Blood type testing not available in donor center).</b>	
I understand that I must meet the same donor criteria as community blood donors. If my blood is found to be incompatible, it will be placed in the community blood supply, and if my unit is found to be unacceptable for transfusion for any reason, it will be discarded. In no way was I forced against my will to donate blood. In the event the unit of blood is not needed by the designated patient, if <b>may not</b> be redesigned for another patient or plan, i.e. replacement.	
Donor's Signature	Date

**Eileen Murphree McMillin Blood Center**  
 First Floor, Fondren-Brown Building, Room # F102

Hours: 8:30 a.m. – 5:30 p.m.

**CLOSED: SATURDAY AND SUNDAY**

Phone: 713/441-3415

Free parking for Blood Donors for time of donation at any Texas Medical Center Garage, Scurlock and Smith Towers

**TELEPHONE ORDER:    ? Yes    ? No**

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Patient: \_\_\_\_\_

By: \_\_\_\_\_

Witness: \_\_\_\_\_