

Dayton
349 S Main St.
Dayton, OH 45402
937-461-3450
1-800-388-4483
Fax 937- 461-9584

Springfield
2200 N. Limestone St., Ste.106
Springfield OH 45503
1-937-399-2611
Fax 937-399-5044

Patient Name: _____ DOB _____

Surgery Date _____ Hospital _____ Surgery Type _____

Number of Units:

Red Cells _____

FFP _____

Other _____

Community Blood Center requests that a patient with significant medical problems has a written medical release prior to donating blood and consider whether donating is a safe procedure for him/her. Please evaluate the medical condition of your patient. **Contraindications include:** Sepsis/active infection, unstable angina, uncontrolled hypertension, scheduled surgery to correct aortic stenosis, sustained ventricular tachycardia, severe left mainstem coronary artery stenosis, active seizure disorder, MI or CVA within 3 months.

By my signature I consider this patient's medical condition satisfactory for autologous donations.

Physician Name _____ Phone _____

Address _____ Fax _____

City/State _____ Zip _____

Physician Signature _____ Date: _____

There must be a minimum of 5 days between the last donation and date of surgery to assure units arrive at the hospital (in our service area) prior to surgery. Units being shipped outside our service area require 7 days.

