# GOOD SAMARITAN HOSPITAL BLOOD DONOR PROGRAM
## (845) 368-5178
## DIRECTED DONATION REQUEST FORM

**NOTE:** This form must be submitted to the Blood Bank by the patient **BEFORE** any Directed Donors will be accepted.

_____ _____
**Patient's Name** **Date of Birth**

_____ _____
**Address** **Telephone #**

_____
**City** **State** **Zip**

I have checked with _____
Name Tel #

my physician who has provided me with the following information:

_____ _____
**Date of Anticipated Blood Transfusion** **Reason for Transfusion**

_____
**Number of Units Needed**

My signature below attests that I have read the patient and donor information sheets about directed donations and understand that blood from donors selected by me is at best no safer than blood from other volunteer blood donors. I hereby request Good Samaritan Hospital Blood Bank to draw directed donors for me.

As stated in the information, I understand that blood from these donors will not be available for me if : donors are not eligible to donate; not ABO or RH compatible; incompatible on crossmatch; rejected by screening tests; broken, contaminated or lost for any reason. I also understand that I accept full responsibility for transfusion. I agree that the Blood Bank accepts no responsibility to notify me regarding incompatible or unsuitable donors but that if necessary I will be able to obtain this information by calling if necessary. I will be able to obtain this information by calling during regular donor hours two days after the donor has donated.

I agree that any blood not used by me will be released into the general inventory 72 hours after the date of anticipated transfusion.

_____ _____
**Patient's Signature (or parent/guardian if minor)** **Date**

**Expected Donors:**

_____ _____
**(name)** **(relationship)**

_____ _____
**(name)** **(relationship)**