Blood Donation Clearance Form

DS-SPDON-F-009 Rev 2

705 E 4th St Chattanooga, TN 37403
Phone # (423) 756-0966 Ext. 1101 or (423) 752-5959 Fax # (423) 752-8484
Email: specialdonations@bloodassurance.org
Attn: Special and Therapeutic Donations

Patient Name: _____ **BA#: (office use)** _____

Patient Address: _____
Street City State Zip

Patient's Birth Date: _____ **Phone #:** _____

Thank you for entrusting the health of your patient with Blood Assurance. Based on a patient's medical history, we sometimes request verification of information in order to assure that the donation process is as safe as possible for the patient. In particular, patients with symptomatic heart or lung disease within the past 6 months are more susceptible to reactions following blood donation. Blood donation can result in up to 10% loss of oxygen-carrying capacity.

Based on my clinical knowledge of this patient, I feel that this patient can safely donate a unit of blood (volume is based on patient's height and weight unless a smaller volume is specified) and the following statements apply

- Reducing the patient's oxygen-carrying capacity by 10% should not result in the patient becoming symptomatic.
- The patient is not symptomatic at rest.
- I have not imposed any physical restrictions on this patient.
- This patient does not require supplemental oxygen.
- This patient is not at increased risk for transmitting a bloodborne pathogen. If the patient is at risk, please let us know in the comments. Regulations require that therapeutic donors with bloodborne pathogens be collected at particular locations. Blood from these donors is discarded.
- Phlebotomy of this patient does not require skilled nursing staff. Phlebotomies at Blood Assurance are performed under the care of phlebotomists only.

Additional comments:_____

_____

Attending Physician Printed Name: _____

Nurse Practitioner (NP) Printed Name (if applicable): _____
If signed by a nurse practitioner, the printed name of the attending physician is required.

Phone #:_____ **FAX #** _____ **Email of office contact** _____

_____ _____ _____
Signature of Attending Physician or NP **E-Signature requires State License #** **Date**

Blood Assurance use only

_____ _____
Signature of Blood Assurance Medical Director or Designee **Date**