



Community Blood Center
Community Tissue Services
Dayton, OH 45402

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

Middletown
3990 Roosevelt Blvd, Ste.C
Middletown, Ohio 45044
513-727-1995
1-800-934-2733

West Chester
8731 Union Centre Blvd
West Chester, OH 45069
1-513-777-4428
1-866-537-6766

Springfield
2200 N. Limestone St.Ste.106
Springfield Ohio 45503
1-937-399-2611

Richmond
4450 Garwood Place
Richmond, Indiana 47374
1-765-962-6329

INSTRUCTIONS/INFORMATION TO PATIENT FOR AUTOLOGOUS COLLECTION

- A. Since your physician has ordered autologous (au-tol'o-gus) transfusions for use in your upcoming surgery, it will be necessary for you to donate your blood. If blood is needed, the blood collected prior to your elective surgery will be given back to you during or after your surgery. Autologous blood is the safest blood for you to receive, since your own blood cannot transmit new diseases.
- B. When you call for your appointment, one of our nurses will discuss the donation process with you. You may call the collection center nearest you to make appointments. Addresses and phone numbers are listed above. Appointments may be scheduled up to six (6) weeks in advance, depending on your physician's order, but no less than 5 days before your surgery date (Monday through Friday, excluding holidays) or 7 days if shipping outside CBC's service area. Appointment days and hours depend on the center hours where you will be donating.
- C. Please have the following information available when calling for your appointment:
1. Your **legal** name, address and phone number.
 2. **Your social security number and date of birth.**
 3. Your **weight, medication list and medical conditions.**
 4. Your **surgery date and hospital.**
- D. Information to remember:
1. The donation process will take approximately 1 - 1 1/2 hours.
 2. Get an adequate night's rest. Eat/drink prior to donation. Eating a high fat diet could cause your blood sample to be unacceptable for testing. Example: eating high fat diet at McDonald's.
 3. Continue to take any medications prescribed or approved by your physician.
 4. Take an iron supplement if ordered by your physician.
 5. Bring your Social Security Number and a picture ID for each appointment (this is required to insure proper identification).
- E. If for any reason your surgery is postponed or canceled, please advise Community Blood Center of the change.
- F. Please be aware that your units will only be given to you if your physician feels transfusion is necessary. Units not used by you will be discarded at the end of their storage period.



G. On very rare occasions, problems can occur at the time of re-infusion of your own blood. This can be due to undiagnosed patient conditions, such as hereditary spherocytosis. Hemolysis may also be caused by improper storage, handling, or infusion of packed red blood cells.

H. **If you have any of the following conditions, autologous donations cannot be undertaken without the completed form below:** Diagnosis of Congestive Heart failure in the previous 3 months. Severe coronary artery disease, heart surgery, heart attack or stroke in the past 3 months. Undiagnosed chest pain, irregular heartbeat; or angina not responding to medication, history of TIA in the past 12 months. A history of seizure activity in the previous 12 months. **Please have your cardiologist/family physician complete this form and bring with you when you come to donate.**

TO THE CARDIOLOGIST/FAMILY PHYSICIAN

Please evaluate and advise Community Blood Center whether you consider autologous donation a safe procedure for this patient.

Contraindications to autologous blood donation.

1. Sepsis/active infection
2. Unstable angina
3. Uncontrolled hypertension
4. Scheduled surgery to correct aortic stenosis
5. Sustained ventricular tachycardia
6. Severe left main coronary artery stenosis
7. Transient ischemic attacks
8. Active seizure disorder
9. Myocardial infarction or Cerebrovascular accident within 3 months

PHYSICIAN MEDICAL RELEASE FOR AUTOLOGOUS BLOOD COLLECTION

Patient name _____

Reason for requesting physician release _____

Additional comments _____

Please mark one of the following:

_____ This patient's medical condition **does not contraindicate** autologous donations.

_____ This patient's medical condition **contraindicates** autologous donations.

Physician name _____ Signature _____

Phone number _____ Date _____