1200 N. Highland Avenue
Aurora, IL 60506
www.versiti.org

Autologous Donor Program
Information & Request Form

The Autologous (Self) donor Program of Versiti Illinois, Inc. allows patients to donate their own blood to meet the anticipated transfusion needs for **planned** surgeries. However, the use of autologous blood has decreased dramatically over the years due to the fact that donor screening protocols and very sensitive blood tests were developed to reduce the risk of transmission of hepatitis and HIV. Collection of autologous units is no longer a standard practice.

Donor Eligibility

It is the responsibility of the patient's physician and the medical staff at Versiti Illinois to determine whether the patient's health will permit the patient to donate safely.

As soon as possible after the decision for surgery is made, please review the information with the patient and complete the last 2 pages of the "Request for Autologous Blood" form on the back of this brochure. Patients should then contact any of the following Versiti Illinois donor centers to schedule an appointment for their donation. Autologous donations are drawn at the following sites: Aurora, Tinley Park, Crystal Lake, DeKalb, Joliet, Winfield, Naperville and Highland, IN. Refer to website https://www.versiti.org/ for specific center locations and hours of operations.

Nearly anyone who is scheduled to undergo a planned surgical procedure that may require the transfusion of blood is eligible to participate in the Autologous Donor Program. However, for the safety of autologous donors, certain guidelines must be followed:

The autologous donor shall not have any heart diseases or other condition which may cause adverse reaction during blood donation.

There are several contraindications to autologous donations:

1. Unmanaged aortic stenosis.
2. Heart Attack (myocardial infarction) within the past 6 months.
3. Hemoglobin less than 12.5 g/dL for females and 13.0 g/dL for males
4. High blood pressure greater than 180/100 mm Hg.
5. Active infection with or without ongoing antibiotic treatment.
6. Seizures within the past 2 months.
7. Patient's weight less than 83 pounds.

Note: In the event the autologous patient is not able to understand the donation procedure or answer reliably the medical history questionnaire given before donation, a legal representative of the patient must be available to provide appropriate medical information and/or donation authorization in case of need.

Frequency of Donations

The patient may donate one time prior to surgery, as the standard 8-week deferral period after donations is applicable for the autologous donor. The donation must be made at least ten days prior to the date of surgery.

On the day of donation, the patient will be given a mini-physical. A medical history, blood pressure, pulse, temperature, and a small sample of blood to test for anemia will be taken. If the patient passes this mini-physical and meets the eligibility criteria, a unit of blood will be drawn. This process will take approximately one hour.

Adverse Reactions

Although rare, a donor may experience an adverse reaction during blood collection or within a few hours after blood drawing. These reactions include, but are not limited to: discomfort, swelling and bruising at the needle site; fainting and convulsions; injury to blood vessels or nerves; infection; and local blood clot. Some reactions may preclude any further autologous donations. In this and other instances, blood from the community blood supply may be needed for the patient's surgery.

To prevent reactions, it is recommended that the donor has something to eat within the two hours preceding the donation.

What Happens to the Blood

A special autologous label with information linking the unit to the patient is affixed to the blood bag. Components requested by the physician retain the special autologous labeling information, and upon meeting testing and processing requirements are delivered to the hospital where the surgery is scheduled.

Charges for Autologous Units

As the Autologous Donor Program requires the services of many trained professionals, special handling of the blood, and additional paperwork, the processing charges for each autologous unit are higher than for other donated blood. Since the blood components requested by the patient's physician are held for the exclusive use of the patient, these charges are assessed even if the blood is never transfused. There are additional charges for shipping the units out of Versiti Illinois' service area. Health insurance (including Medicare) may **not** cover processing fees for autologous blood and/or for additional processing as needed.

Transfusion Outside Versiti Illinois Service Area

Drawing of autologous units to be transferred to hospitals outside the service area needs to be approved by Versiti Hospital Services. **Shipping and processing fees may have to be prepaid for these units.** Whenever autologous blood needs to be shipped to other blood centers, patients are responsible to make arrangements in advance with these centers to assure they will accept these shipments. **Important note:** Autologous units testing **reactive for infectious disease markers** will be shipped depending on acceptance by the physician and transfusing facility. If not accepted, these units will be discarded.

All questions regarding this program may be directed to Versiti Illinois Special Donor Services, at (630) 892-7055.

Please refer to our website, www.versiti.org.

Call one of the centers that collect autologous donations to schedule your donation. The request form must be completed to schedule an appointment.

versiti

Request for Autologous Blood

1200 N. Highland Avenue
Aurora, IL 60506
www.versiti.org

Surgery ID

Patient ID

Unit Number

(Blood Bank Use Only)

Instruction to the Physician: This form will be considered your prescription and must be fully completed and signed. Your patient must present this form at the time of his/her donation. You should carefully review the information contained in this brochure with your patient.

PATIENT INFORMATION

Last Name (please print)

Birthdate

First Name

Middle Init.

Area Code

Home Phone

Street Address

Area Code

Business Phone

Extension

City

State

Zip Code

E-Mail

Area Code

Cell Phone

PATIENT RISK ASSESSMENT

Yes	No	
☐	☐	Does the patient have any heart disease? **If yes, complete CARDIAC CLEARANCE on the reverse side.**
☐	☐	Does the patient have active infection which may serve as a focus for bacteremia?

Contraindications to Autologous Donation

1. Unmanaged aortic stenosis.
2. Myocardial infarction within the past six months.
3. Hemoglobin concentration < 12.5 g/dL for females and 13.0 g/dL for males.
4. Blood pressure greater than 180/100 mm Hg.
5. Bacteremia or treatment for bacteremia.
6. Seizures within the past two months.
7. Patient's weight less than 83 pounds.

TRANSFUSION INFORMATION

Patient Blood Type (ABO & RH)

Date of Surgery

Diagnosis / Surgical Procedure

Hospital

City

If not a system hospital, complete the following information.

Blood Center that supplies the above hospital.

Address

City

Zip Code

RED BLOOD CELLS (42 Days) will be processed from all donations.

Please see other side for completion of order.

CARDIAC CLEARANCE (must be completed if patient has any heart disease/condition)
The afore mentioned patient has the following heart disease/condition(s):

1. _____
2. _____
3. _____
4. _____
5. _____

Note: Patients with heart disease/condition will NOT be drawn if clearance is not obtained in writing from the ordering physician.

By authorizing autologous donation, the physician has determined that the patient is stable enough to tolerate blood donation without ill effects.

PHYSICIAN INFORMATION

I authorize autologous donation for this patient.

Physician Signature

Date - -

Last Name (please print)

Area Code Office Phone - Extension

First Name Middle Init.

Area Code Fax Number -

Office or Clinic Name (as appropriate)

Street Address

E-Mail

City

State Zip Code