



South Texas Blood & Tissue Center

— "Serving the community for over 30 years." —

DIRECTED DONOR LIST

Patient Name: _____

Instructions:

Please list the individual(s) you selected to donate for your surgery. Mark "Yes" if the person is a blood relative or "No" if they are not. Please sign the form when completed.

DONOR NAME(S)

BLOOD RELATIVE?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Statement of Understanding

My physician has explained and I fully understand the directed donation requirements and procedure. Only the people listed above have been contacted and authorized by me to donate blood on my behalf. *

Patient's Signature

(if patient is underage, parent or guardian's signature)

Date

*** NOTE:** Women of child bearing age should not be the recipients of blood donated by their children, their husbands, or their husband's blood relatives, as this could cause red blood cell alloimmunization in future pregnancies.

