



Blood Donation Clearance Form

DS-SPDON-F-009 Rev 1

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 (a potential donor) with Blood Assurance. Based on a potential donor'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, potential donors 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 donor can safely donate a unit of blood (500 mL unless otherwise 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 _____