Carter BloodCare

Autologous Donation

Donating Blood For Yourself

Autologous donations available Monday - Thursday at certain Carter BloodCare fixed sites. Call 817-412-5308. Same day appointments are not available.

Giving blood for your own use is a decision that will be made by you and your physician. The term for this process is autologous donation. The following information is designed to help you make the decision that is right for you.

How do I become an autologous donor?

Your physician must complete and sign an Autologous Request Form and return it to us at least 10 days before your anticipated date of surgery. Once the request is approved, you will receive a call to schedule an appointment at a participating Carter BloodCare Donor Center. Your weight and medical history may determine your eligibility to donate.

How soon should I donate before surgery?

You may donate blood up to 30 days prior to your surgery and no less than five days before your surgery.

How can I be sure that I will receive my own blood?

A special identification tag and bar code is attached to your donation to reserve for your use. A special form is also sent to alert your hospital of your donation. Please know that hospitals and physicians do not inform Carter BloodCare of whether or not you required blood. Your physician's hospital will have this information.

What if my donated units are unused?

Because each autologous donation requires extensive preparation, Carter BloodCare is not able to refund processing and handling fees for unused units. If the autologous units are not used by the patient, the units will be discarded as required by the Food and Drug Administration (FDA).

Where can I donate?

Carter BloodCare offers autologous donation service at certain locations only. When you schedule your appointment you can choose the location that is convenient to you.

Why can I donate for myself more often than I can as a regular donor?

Guidelines from the AABB allow autologous donors to donate with lower hemoglobin (red blood cell) levels than regular donors. Your hemoglobin will be checked before each donation. To maintain your hemoglobin, your physician may prescribe iron supplements.

Can I donate for myself if I have a history of heart disease or stroke?

Only if your cardiologist or internist provides us with a written cardiac clearance letter at least 10 days before your surgery date. A Carter BloodCare physician must also approve before blood is collected.

Will you test my blood?

Each donation is tested for infectious diseases such as hepatitis and HIV. If your donation is unsuitable for transfusion, Carter BloodCare will notify you, your physician and the hospital. We will not disclose your donation information to unauthorized individuals or provide confidential information by phone.

I'm a regular blood donor. When can I donate again?

If you received blood, you will not be eligible to donate again for 12 months after your transfusion.

Autologous Donation

Answers to Your Insurance Questions

What are special donations?

Special donations is a term blood centers use in reference to two types of donations.

- **Autologous donation** is blood you give for yourself before your surgery.
- **Directed donations** are given specifically for you, by blood donors you choose.

Will my health insurance cover autologous donations?

Insurance providers typically will not cover the cost for autologous donations that are not transfused. Because insurance plans change frequently, Carter BloodCare cannot confirm insurance coverage. If you are interested in special donations, please contact your insurance provider to learn how your plan manages autologous donation.

Will my insurance plan cover the blood that is taken from the community blood supply?

Carter BloodCare provides transfusable blood components from the community blood supply. These units are industry standard and are also covered or partially covered by many insurance plans.

If my insurance plan does cover special donations, will Carter BloodCare work directly with my insurance company?

Although Carter BloodCare does not work directly with insurance companies, we will provide a receipt of the charges.

Do I need insurance pre-approval or a physician referral to proceed?

Although hospitals accept autologous units from Carter BloodCare for patients, they will not confirm that a patient's insurance plan covers the costs related to them. To make an autologous donation, your physician must provide Carter BloodCare with a completed and signed Autologous Request Form. You can donate Monday through Thursday at a particpating Carter BloodCare Donor Center. Appointments must be made by calling (817) 412-5308. Walk-ins will not be accepted.

Why would I be charged to make an autologous donation?

Autologous donation is considered elective, except under specific circumstances. Because autologous donations require additional processing apart from the community blood supply, donors are charged for processing, collecting, testing, preparation and tracking of each unit. The cost for autologous donation ranges from $350 to $550* and is required at the time of donation.

Will I pay Carter BloodCare before my donations are made?

Yes. Payment for autologous donation is required at the time of donation and is payable to Carter BloodCare via money order, cashier's check or traveler's check. If arranged in advanced, a credit card may be used. A convenience fee applies for the credit card. Cash is not accepted.

Autologous Blood Donation Checklist

Items to bring with you

- ❑ Proof of Social Security number and a valid unexpired photo ID.
- ❑ Payment for autologous donation will be required at the time of your visit. Carter BloodCare will accept payment for these services via money order, cashier's check or traveler's check, unless prior arrangements have been made.

Getting ready to donate

- ❑ Eat a well-balanced meal within two hours before donation.
- ❑ Drink plenty of non-caffeinated, non-alcoholic fluids.
- ❑ Allow at least one hour for your donation appointment.

Your appointment information

Appointment Date(s) _____

Appointment Time(s) _____

Donor Center/Site _____

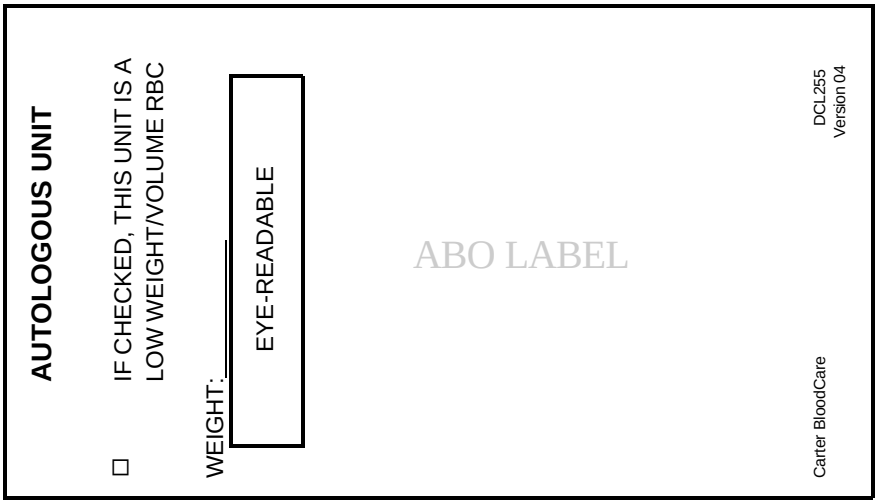
Telephone Number _____

*subject to change.

DCL255 AUTOLOGOUS TAG

Color is Green

FRONT



BACK

BLOOD FOR AUTOLOGOUS TRANSFUSION ONLY
INTENDED RECIPIENT INFORMATION

Prepaid

Collection Date_____ Unit #_____ **Q** YES **Q** NO

Patient Name_____

Sex____ DOB_____ SS# or ID#_____

Hospital_____ Surgery Date_____

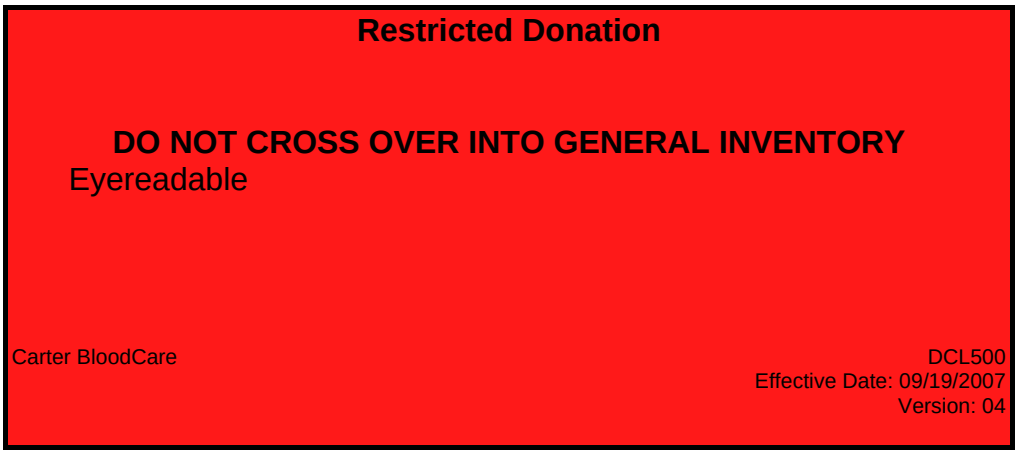
Physician Name_____

Donor Signature_____
(Signature verifies the information is accurate)

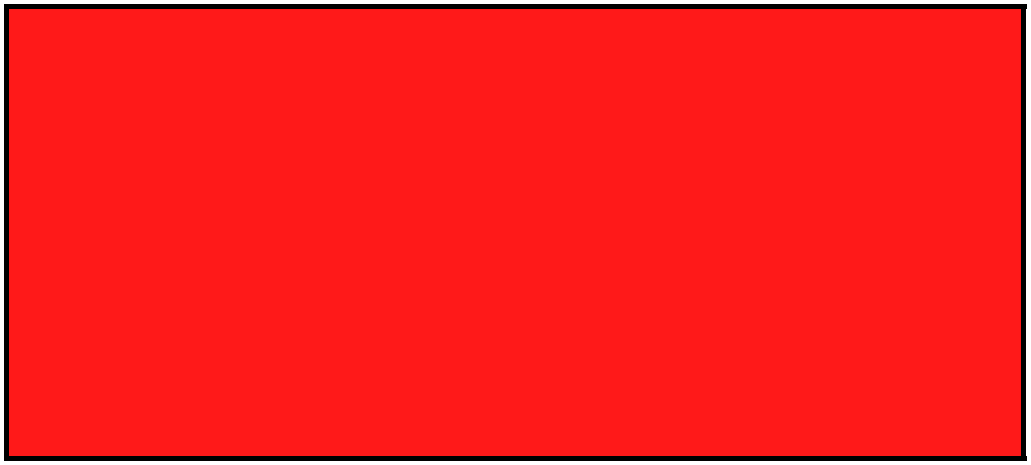
DCL500 Restricted Donation Tag

Color is Orange

Front



Back



Carter BloodCare

ENROLLMENT/PRESCRIPTION FOR NO FEE PHLEBOTOMY FOR HEREDITARY HEMOCHROMATOSIS (HH) PATIENTS ONLY

Please allow 3-5 business days for processing

Donor Notification Dept.: Phone: (817) 412-5603 Fax: (817) 412-5609 Email: DN@carterbloodcare.org

Patient Information (Legibly print patient's legal name as it appears on their driver's license), fill in all blanks:

Full Name: _____ _____ _____ Gender: _____ DOB: _____
Last Name First Name Middle Name

Address: _____
Street City State Zip

Phone #: (_____) _____ Email: _____

Patient Self-Schedules Blood Draws at a Frequency Directed by their Physician

Donation Frequency (mark one): ___ 8-weeks or greater OR ___ up to once every 2 weeks

- One unit (500 mL) of whole blood to be drawn at each donation.
- Males are drawn with Hgb ≥ 13 g/dL and females Hgb ≥ 12.5 g/dL. If patient needs an Hgb target with a lower Hgb value, contact Donor Notification at (817) 412-5603.
- This form is valid for 1 year from the date signed by the physician.
- All fields must be completed for the form to be valid. Additional comments will void the form. Form will be returned if incomplete or amended, resulting in an enrollment delay. Inclusion of patient email will speed patient's receipt of donation instructions.
- For donor eligibility criteria, go to our website: www.carterbloodcare.org
- Carter BloodCare does not perform Ferritin, Iron or other diagnostic tests.

Physician Information: My signature verifies this patient is under my care and has been diagnosed with Hereditary Hemochromatosis confirmed by genetic testing. Patient understands phlebotomy will be provided at no cost to them.

Area for Stamp

Physician Printed Name: _____

Physician Signature: _____

Phone Number: (_____) _____ Address: _____

Fax: (_____) _____ Date: _____

FOR CBC USE ONLY

Donor ID#: _____

Employee Initials: _____ Employee Number: _____ Date: _____

Comments: _____

CBC Medical Director Approval for Phlebotomy: ☐ YES ☐ NO

CBC Medical Director Signature: _____ Date: _____

Carter BloodCare

ENROLLMENT/PRESCRIPTION FOR PHLEBOTOMY DUE TO TESTOSTERONE REPLACEMENT THERAPY (TRT)

Please allow 3 – 5 business days for processing

Contact Donor Notification Phone: (817) 412-5603 for questions Fax: (817) 412-5609 Email: DN@carterbloodcare.org

This form is only required for patients needing to be drawn more frequently than every 8 weeks OR if the patient is unable/declines to donate for the community blood supply.

Patient Information (Legibly print patient's legal name as it appears on their driver's license). Fill in all blanks:

Full Name: _____ (Last Name) _____ (First Name) _____ (Middle Name) Gender: _____ DOB: _____

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Phone #: (_____) _____ Email: _____

Testosterone Therapy Needing Phlebotomy

- One unit of whole blood to be drawn at each donation as frequently as every 2 weeks.
- Patient self-schedules blood draws at the frequency directed by their Physician.
- Males are drawn with Hemoglobin ≥ 13 g/dL and females ≥ 12.5 g/dL and mini-physical is within normal range.
- This form is valid for 1 year from the date signed by the Physician.
- All fields must be completed for the form to be valid. Form will be returned if incomplete, resulting in a delay in enrollment.
- Patients meeting current donor criteria may have their blood used for the community blood supply. Go to website: www.carterbloodcare.org for donor eligibility criteria.
- Inclusion of patient's email will speed patient's receipt of scheduling information.

Physician Information: Area for Stamp:

Physician Printed Name: _____

Physician Signature: _____

Phone Number: (_____)_____ (Area Code, Phone Number) Address: _____

Fax: (_____)_____ (Area Code, Phone Number) Date: _____

FOR CBC USE ONLY

Donor ID#: _____

Employee Initials: _____ Employee Number: _____ Date: _____

Comments: _____

CBC Medical Director Approval for Phlebotomy: ☐ YES ☐ NO

CBC Medical Director Signature: _____ Date: _____

Carter BloodCare

AUTOLOGOUS BLOOD DONATION REQUEST

Physician's office:
Please fax this form at least
10 days before date of surgery to:
817-412-5318

Full Legal Name: _____ SSN: _____
Last First Middle

Patient's Address: _____
Street City Zip Code

Birth Date: _____ Sex: _____ Phone: _____ _____
MM/DD/YY Home Business (& Ext.) Cell

Patient Scheduled for: _____ at _____ on _____
Surgical Procedure/Transfusion Complete Hospital Name Date

Components Needed: [_____] Red Blood Cell RBC [_____] Fresh Frozen Plasma FFP [_____] Cryoprecipitate CRYO
Quantity Quantity Quantity

Pre-Assessment Questions	NO	YES	If "YES," explain
1. Is the patient currently taking an antibiotic or any other medication for an infection?	☐	☐	
2. Has the patient EVER had any type of cancer, including leukemia?	☐	☐	
3. Has the patient EVER had any problems with their heart or lungs?	☐	☐	
4. Has the patient had a bleeding condition or a blood disease?	☐	☐	
5. In the past 6 weeks, has the patient been pregnant or is the patient pregnant now?	☐	☐	

Physician Statement:

I have explained the advantages and disadvantages of autologous blood transfusions to my patient. I realize an autologous donation is not always possible. I also understand that autologous donation may cause my patient to be anemic in the period leading up to the surgery. I understand the blood unit(s) that my patient donates may be unavailable for use due to circumstances beyond CARTER BLOODCARE's control.

I also understand that occasionally, an adverse reaction may occur during or after my patient's donation. Such adverse reactions include, but are not limited to, bruising, accidental arterial puncture, bleeding after leaving the donation site, infection, temporary loss of bladder control, seizure, blood clot formation (thrombosis), vein inflammation (phlebitis), nerve injury and/or a fainting spell which may include dizziness, nausea and vomiting.

I also understand my patient will be assessed a fee for the autologous donation(s).

Physician's Name (Print) _____ Physician's Signature _____ Date _____

Address: No. Street Suite # _____ City State Zip _____

Telephone Number _____ Fax Number _____

CALL 817-412-5308 FOR APPOINTMENTS

For CBC Use Only

Section B: (*Completed by Carter BloodCare Medical Director)*

☐ Approved for autologous donation

☐ Not approved for donation

☐ Prepaid: _____
Amount and Payment Type, i.e., Money Order (MO) ,Credit Card (CC), or NMDP

☐ Waive Fee: _____ _____
Manager/MD Approval Date

☐ MD approval NOT required

_____ _____
Employee Initials/Employee # Date

Comments:

Carter BloodCare Medical Director Signature: _____ Date: _____

Carter BloodCare

AUTOLOGOUS/RESTRICTED WORKSHEET

Patient Name:	Hospital Name:
Social Security Number:	Transfusion/Surgery Date:
Medical Record Number:	Physician Name:
Date of Birth: Sex:	Physician Phone Number:
Procedure:	Physician Fax Number:
Components Ordered: _____ RBC _____ PEDI _____ CRYO _____FFP _____PLT	

Donation Identification Number	Collection Date	Prepaid?		Label Review Acceptable?		
		Yes	No	Yes	No	Initials/Employee # and Date
		☐	☐	☐	☐	
		☐	☐	☐	☐	
		☐	☐	☐	☐	
		☐	☐	☐	☐	
		☐	☐	☐	☐	
		☐	☐	☐	☐	

Comments\Special Instructions:

Carter BloodCare

AUTOLOGOUS/RESTRICTED WORKSHEET

Patient Name:	Hospital Name:
Social Security Number:	Transfusion/Surgery Date:
Medical Record Number:	Physician Name:
Date of Birth: Sex:	Physician Phone Number:
Procedure:	Physician Fax Number:
Components Ordered: _____ RBC _____ PEDI _____ CRYO _____FFP _____PLT	

Donation Identification Number	Collection Date	Prepaid?		Label Review Acceptable?		
		Yes	No	Yes	No	Initials/Employee # and Date
		☐	☐	☐	☐	
		☐	☐	☐	☐	
		☐	☐	☐	☐	
		☐	☐	☐	☐	
		☐	☐	☐	☐	
		☐	☐	☐	☐	

Comments\Special Instructions:

Carter BloodCare
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SDF801.01B
Version: 10
Effective Date: 05/31/2023

Carter BloodCare

TO: _____
Physician Name / Hospital Name

FROM: Carter BloodCare
Special Donations Department and Carter BloodCare Physicians _____
Date

RE: Autologous/Restricted Donation Attempt for _____.
Donor Name

According to our records, _____ unit(s) of blood were to be donated before the procedure. Thus far,

_____ unit(s) have been collected. An attempt was made to draw blood for a

scheduled _____ on _____
Procedure Date

at _____.
Hospital

Unfortunately, blood from that donation attempt will not be available for the procedure.

Listed below is/are the reason(s) the unit(s) will not be available:

____ Donor did not meet our eligibility requirements

____ Quantity of blood collected was not sufficient for transfusion

____ Other: _____

Comments:

_____

_____

_____

_____

NOTE: Donor ____IS ____IS NOT eligible to donate again prior to the procedure. If you have any questions, please contact Special Donations at 1-866-525-3378 or 817-412-5308. We apologize for any inconvenience this may cause.

INSTRUCTIONS

1. Document physician name or hospital name.
2. Document current date.
3. Document donor name.
4. Document quantity of unit(s) to be donated before the procedure.
5. Document quantity of unit(s) that has already been collected from the donor.
6. Document type of procedure, if applicable.
7. Document date the procedure is scheduled.
8. Document hospital where the procedure will be performed.
9. Document the reason the unit will not be available (if “Other,” list reason).
10. Document any additional comments.
11. Document whether donor is or is not eligible to donate again prior to the procedure.

FROZEN AUTOLOGOUS RED BLOOD CELLS – MANAGEMENT RECORD

<table>
<tr><th colspan="3">SECTION A</th></tr>
<tr><td colspan="2">Date:</td><td>Patient Name:</td></tr>
<tr><td>DIN #(s)</td><td>Date Collected:</td><td>Patient Social Security #/ID #:</td></tr>
<tr><td></td><td>Date Collected:</td><td>Physician Name:</td></tr>
<tr><td></td><td>Date Collected:</td><td>Physician Signature:</td></tr>
<tr><td></td><td>Date Collected:</td><td>Physician Phone #:</td></tr>
<tr><td rowspan="2">Surgery Date:</td><td rowspan="2">New Surgery Date: (if Applicable)</td><td>Hospital Name:</td></tr>
<tr><td>Hospital Will Accept Charges: ☐ Yes ☐ No
Spoke with:</td></tr>
<tr><td colspan="2">Reason for Freezing: (please mark appropriate boxes)
☐ The patient has a rare blood type or multiple allo-antibodies or other serologic problem
☐ The patient will need blood for a procedure that cannot be scheduled (i.e., delivery of baby or cadaveric renal transplantation)
☐ The patient has had surgery postponed and will be unable to donate again due to medical conditions</td><td>Comments:</td></tr>
<tr><th colspan="3">SECTION B - For Carter BloodCare Use Only</th></tr>
<tr><td colspan="2">Received By (Emp Initial/#): Date:</td><td>Date Faxed to Distribution:</td></tr>
<tr><td colspan="2">Date Units were Frozen:</td><td>Discard Date: (90 days from date frozen unless otherwise specified)</td></tr>
<tr><td>Physician/Transfusion Service Notified Pending Discard
☐ Yes ☐ No</td><td>☐ OK to Discard
☐ Freeze 90 More Days
☐ Other
Emp. Initials/#: Date:</td><td>Date Component Production Notified:
(only if unit is to be discarded)</td></tr>
<tr><td colspan="3">Comments:</td></tr>
</table>

Carter BloodCare

THERAPEUTIC DONOR REQUEST
(Fee will be Assessed)

For Appointments: Contact Special Donations:
Phone: 817-412-5308
Fax: 817-412-5318
Patients are encouraged to call 2 days prior to needing an appointment.

Section A: Please complete patient/donor information.

Full Name: _____ Sex: _____ DOB: _____
Last First

Address: _____ Phone #: (_____)_____
Street City State Zip Code Area Code

Section B: Diagnosis: ☐ Polycythemia Vera ☐ Polycythemia of unknown origin

*For donors on testosterone or with hereditary hemochromatosis, contact Donor Notification at 817-412-5603

☐ Other: _____

Draw 1 unit of whole blood (approximately 500 mL)

☐ One time only ☐ Every 4 weeks ☐ Every 2 months ☐ Every 3 months

Target Hgb g/dL ☐ 13 g/dL Hgb ☐ 15 g/dL Hgb ☐ Other: _____

(If boxes are left blank, the patient will be drawn at an Hgb of 13 g/dL or above.)

Pre-Assessment Questions

1. Has the patient EVER had any problems with his/her heart or lungs? ☐ No ☐ Yes (describe): _____
   ☐ No ☐ Yes - Oxygen
   ☐ No ☐ Yes - Any Restrictions (describe)
   _____
2. For female patients, in the past 6 weeks has the patient been pregnant or is the patient pregnant now? ☐ No ☐ Yes (describe) _____

Physician's Name: _____

Physician's Signature: _____ Date: _____

Phone #: (_____)_____ Fax #: (_____)_____
Area Code Area Code

For CBC Use Only

Section C:

☐ MD approval NOT required

_____ _____
Employee Initials/# Date

(*Completed by Carter BloodCare Medical Director)*

☐ Approved for 1 time only

☐ Approved for therapeutic donation

☐ Not approved for donation

Comments: _____

_____ _____
Employee Initials/# Date

Carter BloodCare Medical Director Signature: _____ Date: _____

SDF801.03
Version: 10
Effective Date: 05/31/2023

Carter BloodCare

IMPORTANT DOCUMENT
CONFIDENTIAL

AUTOLOGOUS/RESTRICTED BLOOD WITH ABNORMAL TEST RESULTS – NOTIFICATION

PHYSICIAN INFORMATION	
Physician Name:	Telephone Number:
Address:	Fax Number:

PATIENT INFORMATION	
Patient Last Name:	Patient First Name:
Hospital Name:	Donation Identification Number:
Date of Surgery:	Collection Date:

Your patient's blood tested repeatedly reactive for the following screening test(s):

- ☐ HBsAg (Hepatitis B Surface Antigen) Pending Confirmation*
- ☐ Anti-HIV-1/2 (Combination test for antibodies to HIV Type 1 & Type 2) Pending HIV-1 Confirmation & HIV-2 Supplemental Testing*
- ☐ Anti-HTLV-I/II (Antibody to Human T-Cell Lymphotropic Virus) Pending HTLV Supplemental Testing*
- ☐ Anti-HBc (Antibody to Hepatitis B core antigen)
- ☐ Anti-HCV (Antibody to Hepatitis C Virus) Pending Supplemental Testing*
- ☐ Triplex NAT HIV-1/HCV/HBV (Nucleic Acid Amplification Testing to detect HIV-1 RNA, HCV RNA and HBV DNA) Pending HIV-1, HCV and HBV Discriminatory Testing*
- ☐ Syphilis (Treponemal Test) Pending Confirmation*
- ☐ West Nile Virus (WNV)
- ☐ Chagas' Disease (Antibodies to *T. cruzi*)*

*Confirmatory, discriminatory or supplemental test results typically available in 1 – 3 weeks.

If similar findings persist on subsequent donations, you <u>will not</u> be notified.

UNIT DISPOSITION
☐ Unit will be sent to the hospital indicated above.
☐ The hospital does not accept units with this abnormal test result. <u>Unit(s) will be discarded after 24 hours unless otherwise notified.</u>
☐ Unit held pending confirmatory or supplemental testing.
☐ Other (specify):
Carter BloodCare Medical Director: _____ Date: _____

If you have any questions regarding confirmatory/supplemental testing, please call Carter BloodCare's Department of Donor Notification at (817) 412-5603. If you have questions regarding autologous unit availability, please contact the Department for Special Donations at (866) 525-3378.

Therapeutic Donation

Donating Blood For Medical Reasons

Therapeutic donations available Monday - Friday at all Carter BloodCare fixed sites. Call 817-412-5308. Same day appointments are not available.

What is a therapeutic donation?

This type of procedure is provided as treatment for medical conditions or blood disorders. Therapeutic donors do not have to meet the same criteria as an allogeneic donor.*

Will my insurance cover a therapeutic phlebotomy?

Because insurance plans change frequently, Carter BloodCare cannot confirm insurance coverage. If you are interested in a therapeutic donation, please contact your insurance provider to learn how your plan manages a therapeutic donation.

If my insurance plan does cover a therapeutic donation, will Carter BloodCare work directly with my insurance company?

Although Carter BloodCare does not work directly with insurance companies, we will provide a receipt of the charges.

Do I need insurance pre-approval or a physician referral to proceed?

Carter BloodCare will not confirm that a patient's insurance plan covers the cost related to a therapeutic donation. To make a therapeutic donation, your M.D. must provide Carter BloodCare with a completed and signed Therapeutic Request Form. You can donate Monday through Friday at a participating Carter BloodCare Donor Center. Appointments must be made by calling 817-412-5308. Walk-ins will not be accepted.

Will I pay Carter BloodCare before my donation is made?

Yes. Payment for a therapeutic donation is required at the time of the procedure and is payable to Carter BloodCare via money order, cashier's check or traveler's check or if arranged in advance, a credit card. A convenience fee applies for the credit card. Cash is not accepted. The cost for a therapeutic donation is $90 per unit.

Therapeutic donation checklist: Items to bring with you

- ❑ A valid unexpired photo ID.
- ❑ Payment for therapeutic donation, unless prior arrangements have been made will be required at donor center via money order, cashier's check or traveler's check.

Getting ready to donate

- ❑ Eat a well balanced meal within two hours before donation.
- ❑ Drink plenty of non-caffeinated, non- alcoholic fluids.
- ❑ Allow at least one hour for your appointment.

For an appointment please call Special Donation at **(817-412-5308)**

Your appointment information

Appointment Date(s)

_____

Appointment Time(s)

_____

Donor Center/Site

_____

Telephone Number

_____

*Subject to change. Please call 817-412-5308 for details

*Certain exceptions apply for HH and LOT programs