Carter BloodCare

STATEMENT OF MEDICAL NECESSITY

Date: _____

Patient Name: _____

Patient Identification Number: _____

Patient ABO/Rh: _____

Name of Transfusing Facility: _____

Product: _____

Reason for Deviation from Standard Operating Procedures:

Medical Necessity Documentation: (Completed By Attending Physician or Designee)

Current conditions dictate that these blood products are needed with sufficient urgency for recipient/patient.

_____

Hospital Representative Signature Date

_____

Hospital Representative Printed Name

_____

Facility

www.carterbloodcare.org
1-800-DONATE-4

Carter BloodCare
2205 Highway 121
Bedford TX 76021
817-412-5000