Western Cape Blood Service
Do something remarkable

Clinician's Request for Designated Donations at WCBS

Patient's Details

First Name: .....

Surname: .....

Date of birth: .....

Telephone (h): .....**(w):** .....**(c)** .....

E-mail: .....

Diagnosis: .....

Hospital: .....

Date and time of transfusion: .....

Blood Product Requirements

Blood product	Number of units required	Indicate with 'x' if leucocyte reduction is required	Indicate with 'x' if irradiation is required
Adult whole blood			
Adult red cell concentrate			
Paediatric red cell concentrate			
Paediatric whole blood			
Infant red cell concentrate			
Fresh frozen plasma			
Other:			

Clinician's Details

I, the undersigned:

- Understand that blood from the general supply is available, should the need arise.
- Understand that the designated donors must fulfil the specific donor acceptance criteria of WCBS.
- Understand that should the date and time of the transfusion change, it is my responsibility to inform WCBS accordingly.

Name: .....

Address: .....

Telephone: ..... **Fax:** .....

Email: ..... **Practice No**.....

Signature: ..... **Date:** .....

WCBS Specialised Donations
Tel: (021) 507-6393 or (021) 507-6320 | E-mail: phlebotomy@wcbs.org.za