Blood Collection Authorization Form

Main OPCCS HHTC KTC BTC VTC Troy KEP CHP

Patient Label

Today's Date:_____

Time:_____

Patient Name:_____

Patient's Current Weight:_____

Maximum Blood Draw Amount (per guidelines):_____

Ordering Physician:_____

Tests Ordered and Minimum Volumes:

_____

_____

_____

Total Blood Required:_____

Test Priority:_____

Phlebotomist Name:_____

Phlebotomist Tech. Code:_____

Phlebotomist Signature:_____

My signature below confirms that I acknowledge and consent to the phlebotomist to obtain _____(mL) above the recommended maximum by Dayton Children's Hospital Volume Guidelines for Blood Collection Policy.

Nurse Practitioner/ Physician

Signature:_____
(*** If signature is not available, a witness signature is required***)