National Blood Transfusion Service
Guardamangia Hill,
Pietà PTA 1314 Malta
Tel: *21234047*

Website: *www.blood.gov.mt*
E-mail: *customercare.nbts@gov.mt*

Blood Donation Centre
St Luke's Square,
Guardamangia PTA 1010 Malta
Tel: *21234767 / 22066201 / 79307307*
Free Phone: *80074313*

Facebook: *www.facebook.com/bloodmalta*
Mobile App: *Blood Donors MT*

Autologous Transfusion Referral Letter

Date __________________

Dear Colleague,

This patient has requested Autologous Transfusion for his / her operation. I have discussed this with the patient and am of the opinion that he / she is medically suitable for the procedure.

I would be grateful if you could see him / her with a view to making the necessary arrangements.

Patient's Name and Surname ______________________

Patient's ID Card No. ______________________

Patient's Date of Birth ______________________

Patient's Address ____

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Hospital ______________________

Ward ______________________

Ward Tel. Number ______________________

Date of Admission ______________________

Date of Operation ______________________

Medical Conditions ____________________________________

Requested Number of Donations (________) (maximum is 5)

Haemoglobin Level ________ g/dL

______________________________ ____________________

Name of Referring Consultant Clinician (Block Letters)

Signature of Referring Consultant Clinician

DONFOR-005-080322-04

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