

BLOOD PRODUCT TRANSFUSION ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI _____ DOB: _____

HT: _____ in WT: _____ lbs kg Sex: Male Female Allergies: NKDA, _____

Physician Name _____ Contact Name _____ Contact Phone # _____

NPI #: _____ Tax ID#: _____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD 10 CODE + DESCRIPTION) _____

Secondary Diagnosis: (ICD 10 CODE + DESCRIPTION) _____

PERTINENT MEDICAL HISTORY

Does patient have venous access? YES NO If yes, what type MEDIPORT PIV PICC LINE OTHER: _____

1) Is the patient incontinent? Yes No 2) Is the patient ambulatory? Yes No

2) Has the patient taken Darzalex (daratumumab) within the last 6 months? Yes No

3) Has type and cross been drawn? Yes No If yes, date and time _____. If no, patient to go to hospital lab on _____ date/time OR _____ to be drawn at Infusion Center on arrival.

NOTES: _____

PRESCRIPTION ORDERS:

- a) ALL MEDIPOINTS / IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL POLICY PRN
- b) 500 mL BAG OF 0.9% NS MAY BE HUNG AT KVO RATE
- c) TUBING WILL BE FLUSHED WITH 0.9% NS UNTIL TUBING IS PINK TINGED OR CLEAR
- d) H+H MUST BE COMPLETED WITHIN ONE WEEK OF ALL BLOOD PRODUCT TRANSFUSIONS

TYPE, CROSSMATCH, AND TRANSFUSE:

SELECT	# of UNITS	PRODUCT
<input type="checkbox"/>		FRESH FROZEN PLASMA
<input type="checkbox"/>		LEUKO REDUCED PRBCs
<input type="checkbox"/>		LEUKO REDUCED IRRADIATED PRBCs
<input type="checkbox"/>		LEUKO REDUCED PLATELETS
<input type="checkbox"/>		LEUKO REDUCED IRRADIATED PLATELETS
<input type="checkbox"/>		PLATELETS TYPE SPECIFIC? <input type="radio"/> Yes OR <input type="radio"/> No
<input type="checkbox"/>		Other: _____

LABS

SELECT	LAB REQUESTED	WHEN
<input type="checkbox"/>	NONE	NA
<input type="checkbox"/>	BMP	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST
<input type="checkbox"/>	CMP	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST
<input type="checkbox"/>	CBC w/ DIFF	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST
<input type="checkbox"/>	H+H:	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST
<input type="checkbox"/>	T+C:	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST
<input type="checkbox"/>	Other:	<input type="checkbox"/> PRIOR <input type="checkbox"/> POST

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY
<input type="checkbox"/>	NONE	NA	NA	NA
<input type="checkbox"/>	BENADRYL			
<input type="checkbox"/>	ACETAMINOPHEN			
<input type="checkbox"/>	OXYGEN			
<input type="checkbox"/>	LASIX			
<input type="checkbox"/>	Other: _____			

NOTES/INSTRUCTIONS/COMMENTS

DIETARY RESTRICTIONS (If none, please indicate): _____

Physician's Signature _____ Time _____ Date _____
 *Signature Must Be Clear and Legible

Cosignature (If Required) _____ Time _____ Date _____
 *Signature Must Be Clear and Legible

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.