NORTHEAST REGIONAL
Infusion Services
AT
Richardson
MEDICAL CENTER
PHONE: (318) 728-8237 FAX: (877) 249-1191

☐ **STAT REFERRAL**

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 MEDIPORTS / 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
e) FOLLOW-UP WITH PHYSICIAN FOR POST TRANSFUSION LABS

TYPE, CROSSMATCH, AND TRANSFUSE:

SELECT	# of UNITS	PRODUCT
☐		FRESH FROZEN PLASMA
☐		LEUKO REDUCED PRBCs
☐		LEUKO REDUCED IRRADIATED PRBCs
☐		LEUKO REDUCED PLATELETS
☐		LEUKO REDUCED IRRADIATED PLATELETS
☐		PLATELETS TYPE SPECIFIC? ○ Yes OR ○ No
☐		Other:

LABS

SELECT	LAB REQUESTED	WHEN
☐	NONE	NA
☐	BMP	☐ PRIOR
☐	CMP	☐ PRIOR
☐	CBC w/ DIFF	☐ PRIOR
☐	H+H:	☐ PRIOR
☐	T+C:	☐ PRIOR
☐	Other:	☐ PRIOR

PREMEDS

SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY
☐	NONE	NA	NA	NA
☐	BENADRYL			
☐	ACETAMINOPHEN			
☐	OXYGEN			
☐	LASIX			
☐	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.