Comanche County Memorial Hospital

Outpatient Blood Transfusion Order Form

Phone: 580-250-5899 | Fax: 580-585-5472

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____
HT: _____ WT: _____ DOB: _____ Sex: ( ) Male ( ) Female SSN: _____
Street Address _____ _____ City/Stale/Zip _____
Home Phone # _____ Work # _____ Cell # _____

INSURANCE INFORMATION

Primary Insurance Name _____ Policy ID# _____
Secondary Insurance Name _____ Policy ID# _____

PHYSICIAN/FACILITY INFORMATION

Physician's Name _____ Contact Name _____ Contact Phone # _____
Address _____ City/State/Zip _____ Fax #: _____
DEA# _____ NPI# _____ State License # _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis (ICD 10 code AND CPT code) _____
Secondary Diagnosis (ICD 10 code AND CPT code) _____

MEDICAL INFORMATION

Does the patient have venous access? ☐ Yes ☐ No If yes, what type? _____
Is the patient incontinent? ☐ Yes ☐ No Comments: _____
Is the patient ambulatory? ☐ Yes ☐ No Comments: _____

***ALL MEDIPORTS WILL BE FLUSHED WITH SALINE + HEPARIN PER HOSPITAL PROTOCOL**
***CBC RESULTS MUST BE DRAWN 48 HOURS PRIOR UNLESS MEDICAL NECESSITY CAN BE ESTABLISHED**
***250 mL BAG OF NORMAL SALINE WILL BE HUNG TO CLEAR ALL PATIENT LINES**

***EACH UNIT OF BLOOD WILL BE TRANSFUSED OVER 2 HOURS UNLESS CONTRAINDICATED OR OTHERWISE SPECIFIED BY PHYSICIAN**

TYPE, CROSSMATCH, AND TRANSFUSE:

_____ Units ☐ Leukocyte Reduced RBC's
_____ Units ☐ Leukocyte Reduced Irradiated RBC's

PLATELETS:

_____ Units ☐ Leukocyte Reduced Platelets
_____ Units ☐ Leukocyte Reduced Platelets Irradiated Platelets

PRE-MEDICATIONS:

☐ Benadryl PRN: _____ mg ☐ PO ☐ IV ☐ IVP
☐ Acetaminophen PRN: _____ mg ☐ PO ☐ IV ☐ IVP
☐ Lasix between Units: _____ mg ☐ PO ☐ IV ☐ IVP
☐ Other: _____
☐ Oxygen: _____
☐ Diet: _____

FLUSHES:

☑ **10 mL NS Flush Syringe PRN** ☑ **Heparin 500units/5mL Flush Syringe PRN** ☑ **250mL NS PRN**

LABS NEEDED PRIOR: _____

LABS NEEDED POST: _____

Physician's Signature _____ Date: _____ Time: _____

Fax completed form to the Outpatient Infusion Center at 580-585-5472. PLEASE include copies of: H&P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, LETTER OF NECESSITY or any other documentation supporting the use of infusion therapy, and ALL current insurance information for your referral to be processed.