



Outpatient Infusion Center Blood Transfusion Order

Please fax form to: 580-585-5472

Patient Information

Patient Name: _____ DOB: _____ Phone: _____ Gender: M F
Patient Address: _____ Email: _____ Insurance: _____

Additional Information Needed

Fax front/back of insurance card Fax clinical/progress notes Fax labs
Fax patient demographics Fax current medication list Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

Primary Diagnosis: Code: _____ Description: _____
Secondary Diagnosis: Code: _____ Description: _____

Clinical Information:

New Therapy Induction Therapy Change Therapy Continuation
Patient Weight: _____ lbs/ _____ kg Patient Height: _____ in/ _____ cm
Allergies: _____
Therapies Tried and Failed: _____
Does the patient have venous access? Yes or No If yes, What type? _____
If No, initiate IV access.

Orders

**ALL MEDIPOINTS WILL BE FLUSHED WITH SALINE + HEPARIN PER HOSPITAL PROTOCOL
DO NOT ADMINISTER HEPARIN TO THIS PATIENT**
(Unless the box is checked all PICC lines, Ports, Midlines, and Central Lines may be flushed with Heparin and Saline)
CBC RESULTS MUST BE DRAWN 48 HOURS PRIOR UNLESS MEDICAL NECESSITY CAN BE ESTABLISHED
250mL 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

Lab Orders to be done by

Infusion Services
Referring Provider

Pre-medications

Benadryl _____mg
PO IVP PRN sensitivity
Acetaminophen _____mg
PO IVPB PRN mild pain

Type, Crossmatch, and Transfuse

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

Misc Orders

Labs prior to transfusion _____
Labs post transfusion _____
PICC/Midline/CAD dressing to be changed every 7 days
Other _____

Flushes

10mL NS Flush Syringe PRN
Heparin 500units/5mL Flush Syringe PRN
50ml NS Bag PRN
250ml NS Bag PRN

Standing Orders for Adverse Reaction

Stop infusion and initiate NS bolus Epi 1:1000 1mL IM, IV or SQ for anaphylaxis
Notify Supervising physician and ordering provider Oxygen 2-5L nasal cannula
Solu-Cortef 100mg SIVP signs of adverse reaction Albuterol 2.5mg inhaled PRN to chest tightness
Benadryl 25 mg SIVP for hives or bronchial inflammation Other: _____

Prescriber Information

Physician Name: _____ Official Contact Name: _____
Contact #: _____ Fax Number: _____
Address: _____ City/State/Zip: _____
NPI#: _____ DEA#: _____ State License #: _____

Physician's Signature _____ Date _____ Time _____

