Comanche County Memorial Hospital

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 patient demographics
- ☐ Fax clinical/progress notes
- ☐ Fax current medication list
- ☐ Fax labs
- ☐ 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 MEDIPORTS WILL BE FLUSHED WITH SALINE + HEPARIN PER HOSPITAL PROTOCOL**
- ☐ **DO NOT ADMINISTER HEPARIN TO THIS PATIENT**
  (Unless the box is checks 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 Irradiated RBC's _____ Units
- ☐ Leukocyte Reduced Platlets _____ 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
- ☐ Notify Supervising physician and ordering provider
- ☐ Solu-Cortef 100mg SIVP signs of adverse reaction
- ☐ Benadryl 25 mg SIVP for hives or bronchial inflammation
- ☐ Epi 1:1000 1mL IM, IV or SQ for anaphylaxis
- ☐ Oxygen 2-5L nasal cannula
- ☐ Albuterol 2.5mg inhaled PRN to chest tightness
- ☐ Other: _____

Prescriber Information

Physician Name: _____ Official Contact Name: _____

Contact #: _____ Fax Number: _____

Address: _____ City/State/Zip: _____

NPI#: _____ DEA#: _____ State License #: _____

_____ _____

Physician's Signature Date Time