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