

**SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
BLOOD PRODUCT TRANSFUSION ORDER FORM**

STAT REFERRAL

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI _____ DOB: _____
HT: _____ in WT: _____ 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
3) Has the patient taken Darzalex (daratumumab) within the last 6 months? Yes No
4) Has type and cross been drawn? Yes No If yes, date and time _____. If no, patient instructed 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 PROTOCOL PRN
B) 500 cc BAG OF 0.9% NS MAY BE HUNG WITH EACH BLOOD PRODUCT TRANSFUSION
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

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? <input type="radio"/> Yes OR <input type="radio"/> No
		Other: _____

LABS

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

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*