Southwestern Medical Center
Empowered by ScionHealth
Phone: 580-531-4892
Fax: 877-249-1191

☐ **STAT REFERRAL**

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES

BLOOD PRODUCT TRANSFUSION ORDER FORM

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? O Yes O No 2) Is the patient ambulatory? O Yes O No

2) Has the patient taken Darzalex (daratumumab) within the last 6 months? O Yes O No

3) Has type and cross been drawn? O Yes O No If yes, date and time __________. If no, patient 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 POLICY PRN
b) 500 mL BAG OF 0.9% NS MAY BE HUNG AT KVO RATE
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? O Yes OR O 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*

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.