

BLOOD PRODUCT TRANSFUSION ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____

HT: _____ in WT: _____ ☐ lbs ☐ 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

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

3) Has type and cross been drawn? ☐ Yes ☐ 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? ☐ Yes OR ☐ 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*