Center for Infusion Care
HILLSDALE HOSPITAL
Phone: (517) 212-4336 | **Fax:** (877) 249-1191
hillsdalehospital.com/infusion

☐ **STAT REFERRAL**

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

2) Has the patient taken Darzalex within the last 6 months? **YES** **NO**

3) 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? ○ 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*

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