

**Infusion Center
Blood Products Order Form**

**To schedule an appointment, please call
303-603-3553 | fax 303-269-4759**

Patient Information

Patient Name _____
DOB _____ SSN _____
Home Phone _____ Other Phone _____
Insurance _____ Auth # (if needed) _____

Date/Time (must include) _____
RX _____ Signature _____
Diagnosis _____ ICD-10 _____

Blood Product Order Information

High: _____ Hct: _____ (or attach copy of lab work) Platelets: _____ (for platelet transfusion only)

Type & Crossmatch for _____ units of Packed Red Blood Cells

Irradiated CMV Neg

Type & Crossmatch for _____ units of Platelets

Irradiated CMV Neg

Premedication

- Tylenol 650 mg PO every 4 hours PRN for transfusion reactions
- Benadryl 25-50 mg PO/IV every 4 hours PRN for transfusion reactions
- Solumedrol 125 mg IV PRN for transfusion reactions

Transfusion Order

Transfuse _____ units Packed Red Blood Cells per protocol on ____/____/____ (date)

Transfuse _____ units of Platelets per protocol on ____/____/____ (date)

Discharge patient when stable after transfusion complete

May utilize central line per protocol

Other Orders: _____

Results

- STAT Read & Call
- Hold Patient & Call Results
- Fax Results Only

Physician Information (must be completed)

Physician Name _____
Phone _____ Fax _____
Physician Signature _____ Date _____

Parker Adventist Hospital

