The Outpatient Infusion Center
a Service of Comanche County Memorial Hospital
Phone: 580-250-5899
Fax: 580-585-5472

BLOOD TRANSFUSION ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____
HT: _____ WT: _____ DOB: _____ Sex :( ) Male ( ) Female SSN:_____
Street Address_____ City/State/Zip _____
Home Phone # _____ Work # _____ Cell # _____

INSURANCE INFORMATION

Primary Insurance Name_____ Policy ID# _____
Secondary Insurance Name_____ Policy ID# _____

PHYSICIAN/FACILITY INFORMATION

Physician's Name_____ Contact Name _____ Contact Phone # _____
Address _____ City/State/Zip_____Fax #:_____
DEA# _____ NPI # _____ State License # _____

STATEMENT OF MEDICAL NECCESITY

Primary Diagnosis (ICD 10 code AND CPT code) _____
Secondary Diagnosis (ICD 10 code AND CPT code) _____

MEDICAL INFORMATION

Does the patient have venous access? ☐ Yes ☐ No If yes, what type? _____
Is the patient incontinent? ☐ Yes ☐ No Comments: _____
Is the patient ambulatory? ☐ Yes ☐ No Comments: _____

***ALLMEDIPORTS WILL BE ACCESSED AND FLUSHED WITH SALINE + HEPARIN PER HOSPITAL PROTOCOL**
***CBC RESULTS MUST BE DRAWN 48 HOURS PRIOR UNLESS MEDICAL NECESSITY CAN BE ESTABLISHED**
***500 mL BAG OF NORMAL SALINE WILL BE HUNG TO CLEAR ALL PATIENT LINES**
***EACH UNIT OF BLOOD WILL BE TRANSFUSED OVER 2 HOURS UNLESS CONTRAINDICATED OR OTHERWISE SPECIFIED BY PHYSICIAN**

TYPE, CROSSMATCH, AND TRANSFUSE:

_____ Units ☐ Leukocyte Reduced RBCs

_____ Units ☐ Leukocyte Reduced Irradiated RBCs

PLATELETS:

_____ Units ☐ Leukocyte Reduced Platelets

_____ Units ☐ Leukocyte Reduced Irradiated Platelets

FLUSHES:

PRE-MEDICATIONS:

☐ Bendaryl PRN: _____ mg ☐ PO ☐ IV ☐ IVP

☐ Acetaminophen PRN: _____ mg ☐ PO ☐ IV ☐ IVP

☐ Lasix between Units: _____ mg ☐ PO ☐ IV ☐ IVP

☐ Other: _____

☐ Oxygen:_____

☐ Diet: _____

☐ 10mL NS Flush Syringe PRN ☐ Heparin 500units/5mL Flush Syringe PRN ☐ 10mL NS Flush Syringe PRN ☐ 250mL NS PRN

LABS NEEDED PRIOR:_____
LABS NEEDED POST:_____

Physician's Signature _____Date_____ Time:_____

Fax completed form to the Outpatient Infusion Center at 580-585-5472. PLEASE include copies of: H&P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, LETTER OF NECESSITY or any other documentation supporting the use of infusion therapy, and ALL current insurance information for your referral to be processed.