

Outpatient Infusion Clinic – Blood Transfusion Order

Patient Name: _____ DOB: _____

Reason for Transfusion: _____ Allergies: _____

Admit to Outpatient Infusion Clinic on _____ (date) for blood transfusion.

Diagnosis:

☐ Specify ICD-10 code: _____

Type and cross-match _____ unit(s) of PRBCs and give to patient on _____ per protocol.

Patient MUST type and cross-match at OGHS South Campus day before scheduled transfusion.

Pre-medication (30 minutes prior to transfusion):

- ☐ Benadryl 25mg IV x1
- ☐ Benadryl 25mg PO x1
- ☐ Tylenol 650mg PO x1

Y/N (circle) OK to access medi-port for transfusion. De-access after transfusion per protocol.

If there is an infusion related reaction, the nurse will stop the infusion immediately and follow OGHS protocol for reaction. Referring physician will be notified.

Physician (Printed) Name: _____

Signature:

Date:

Time:

Fax completed form to 337-594-1290

You MUST also include:

- Patient's labs including CBC
- Insurance information (demographics or front/back copy of card)
- Copy of patient's photo ID

Please call us with any questions at (337) 678-4856