Troy Infusion Center
600 W Main Street
Suite 120
Troy, OH 45373
Phone: 937-401-6620
Fax: 937-401-6629

Washington Township Infusion Center
1989 Miamisburg-Centerville Road
Suite 101
Dayton, OH, 45459
Phone: 937-401-6620
Fax: 937-401-6629

Blood Transfusion Order Form

Epic Referral: REF192

Patient Name: ____ **DOB:** _______________________

Address: ____

Phone: ___________________________________ **Bed** or **Recliner** (please circle one)

Diagnosis: ☐ Anemia – D64.9 **Other Diagnosis**: _________________________

Transfuse:

☐ 1 unit PRBC IV	☐ 2 units PRBC IV	☐ 1 unit Platelets single donor IV
☐ Irradiated	☐ Irradiated	☐ Irradiated
☐ Leukopoor	☐ Leukopoor	☐ Leukopoor

****Type and Cross must take place within 72 hours of when patient will receive blood transfusion. If patient has not had type and cross completed, this will serve as an order to do onsite. ****

Pre-meds:

☐ Tylenol 1000 mg po or ☐Tylenol 650 mg po

☐ Benadryl ____ mg po or ☐ Benadryl _____ mg IV

☐ Other: ____

Lasix: (given in between units or after 1 unit)

☐ Lasix 10 mg IV push or ☐ Lasix 20 mg IV push or ☐ Lasix 40 mg IV push

Additional Orders: ____

Special Precautions: ____

Labs: HGB____________g/dL Date Drawn: __________
HCT____________g/dL Date Drawn: __________
Platelet Count: ______x1000 Date Drawn: __________

Please send copy of lab results with order form.

Lab Orders: ____

Prescriber Printed Name:____

Prescriber Full Address: ____

Office Phone Number: _______________________ **Office Fax Number:** ______________________

Prescriber Signature: ____ **Date:** ___________________