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: _____

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:** _____