Approved: ____________

Scheduled: ____________

Nursing Outpatient Services (NOPS)

TRANSFUSION REFERRAL FORM

Referring Provider: ________________________________ Phone: ________________
Patient Name: ____________________________________ Phone: ________________
DOB: ____________________ Allergies: ______________________________________
Height: ____________ Weight: ________________
Resuscitation status: □ Full Resuscitation □ DNR □ DNI □ Other ____________________

Diagnosis: ____
ICD-10: ____________________

Transfuse _______ units packed cells over _____ hours each
□ Pause _______________ between units
Other: ______________________________

Medications:
□ Furosemide _____mg IV between units
□ Other:_________________

Lab Orders:
□ T&C _____ units
□ Hematocrit 30 minutes after transfusion
□ Other ____________________________

Required Support Documentation
□ Recent chart note or H&P
□ Is insurance Medicare?
□ Include pre-authorization by insurance if not Medicare

X ____
Referring Provider

Printed Name:
____

Date:
____

Please FAX completed form to 509-493-5102