SKYLINE HEALTH

PHONE: 509-637-2814 FAX: 509-493-5102

PATIENT NAME:

BIRTHDATE:

Phone:

OUTPATIENT NURSING SERVICES
Please FAX completed form.

BLOOD PRODUCT TRANSFUSION ORDER FORM

Allergies: _____

Height: _____ Weight: _____ Date of last weight: _____

Resuscitation status: □ Full Resuscitation □ DNR □ DNI □ Other_____

Diagnosis: _____
ICD-10:

Transfuse _____ units packed cells over _____ hours each Frequency: _____

Other blood product orders: _____

SPECIAL INSTRUCTIONS:
_____

Start date: _____ End date: _____

Medications:
□ Furosemide _____mg IV between units
□ Other pre or post medication order:

Lab Orders:
□ T&C _____ units Frequency: _____ Parameters: _____
□ Hematocrit prior to transfusion
□ Hematocrit 30 minutes after transfusion
□ Other desired lab order(S):

Referring Provider (print) _____

Referring Provider Signature: _____ Date: _____

Referring Provider Phone: _____ Referring Provider Fax# _____