



Ambulatory Infusion Center

Patient Referral and Prescription for Blood Transfusion
Return Signed RX via Fax to 1-888-310-0856

To: Tina Benkendorfer, Pharm.D.		From:	
Fax Number: 1-888-310-0856		Phone Number:	
Preferred Start Date:		Number of Pages Faxed, Including Cover:	
Patient Name:		DOB:	
Diagnosis/ICD-10:	Height:	Weight:	Allergies:

BLOOD/BLOOD PRODUCTS

Type and Screen is automatically ordered

Packed Blood Cells (RBC): Reason for transfusion (must be documented): Hgb < or = 7g/dL Hgb < or = 8g/dL
for preoperative or on a chronic transfusion regimen **Other** _____

Packed Cells (RBC) _____ units at a rate of 150 ml/hour (approximately over 2 hours)
 Packed Cells (RBC) _____ units at a rate of 100 ml/hour (approximately over 3 hours. Cannot exceed 4 hours)
 IV Fluid: 0.9% NaCl 250 ml to be infused during blood transfusion at 30 ml/hour

Platelets: Reason for transfusion (must be documented): Platelets < 20,000/ μ L Platelets < 50,000/ μ L
preoperative **Other** _____

Transfuse Platelet Pheresis (Single Donor) at a rate of 500 ml/hour (approximately over 30 minutes)

Other Orders:

Acetaminophen (Tylenol) 650 mg PO pretransfusion Acetaminophen (Tylenol) _____
 Diphenhydramine (Benedryl) 25 mg IV pretransfusion Diphenhydramine (Benedryl) 25 mg po pretransfusion
 Diphenhydramine (Benedryl) _____

Furosimide (Lasix) 20mg IV after first unit of blood Furosimide (Lasix) _____
 Bumetanide (Bumex) 1mg IV after first unit of blood Bumetanide (Bumex) _____

IV Access Device: Establish/manage IV access and flush IV access device per policy
 (Use normal saline solution for peripheral access, and heparin 100 units/ml solution for central access.)

Laboratory Orders: _____

Dietary Orders: Patient may have general diet during visit OR _____
 Additional Comments/Orders: _____

CONSENT: I have provided the patient with a copy of the state Department of Health Services information sheet, *A Patient's Guide to Blood Transfusion*, concerning the advantages, disadvantages, risks and benefits of autologous blood and of directed and non-directed homologous blood from volunteers. I have also allowed adequate time prior to surgery for the patient or other person to predonate blood for transfusion purposes, except where there is a life-threatening emergency, there are medical contradictions, or the patient has waived this right.

Prescriber's Signature: _____ Date: _____ Time: _____

Print Prescriber's Name: _____ NPI# _____

Please fax the following information:
 Patient Demographics – include insurance information. **We will obtain authorization** unless the insurance dictates otherwise.
 H & P **OR** progress note(s) describing diagnosis and clinical status
 Recent Laboratory Results

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