



****Transfusion Services Form ONLY****

Fax this form and a face sheet to: 920.623.6469 **AND** call to schedule: 920.623.6466

***After hours call House Supervisor at 920.382.3913 or x3344 (after 2 p.m. during week/after 12 p.m. weekends)*

Central venous access device? YES NO

Type _____

Reason for transfusion

- HCT \leq 21%
- HGB \leq 7mg/dL
- Active blood loss (\geq 15%)
- PLT count $<$ 10,000/uL in non-surgical, non-bleeding patient
- PLT count $<$ 50,000/uL and significant bleed or invasive procedure within 6 hours
- Other _____

Patient Label

Patient Name: _____

DOB: _____

Phone #: _____

Allergies:

BLOOD PRODUCTS NEEDED:

CMV Negative? YES NO

Irradiated? YES NO

Packed Red Blood Cells:

Type and Crossmatch for _____ units on _____ (date)

Administer _____ units of PRBC on _____ (date)

Infuse each unit over _____ hours

Blood warmer needed: YES NO

Platelets:

Administer _____ units of SINGLE DONOR apheresis platelets on _____ (date)

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***Use Infusion Form for Instructions**

Medications:

Premeds (To be given 1/2 hour prior to transfusion):

- Acetaminophen 650mg PO
- Diphenhydramine 25 mg PO
- Diphenhydramine 50 mg PO

Other meds:

- Lasix _____ mg IV push before / after _____ unit

Other Orders (include ICD-10):

**Centralized scheduling to send to lab and unit*

Provider Signature: _____

Provider Name (Printed): _____

Date / Time: _____

Direct Phone #: _____