Prairie Ridge HEALTH
Inspired by you

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 ≤ 21%
- ☐ HGB ≤ 7mg/dL
- ☐ Active blood loss (≥ 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 ½ 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 #: _____