COFFEE REGIONAL MEDICAL CENTER

1PO

BLOOD/BLOOD PRODUCT TRANFUSION ORDERS

Patient Name:_____

DOB:_____Phone #:_____

Pre−cert #:_____

Primary Care Physician:_____

Outpatient Therapy − 1st Floor − CRMC − Phone: 912−384−1900 ext 4420
Fax: 912−383−5663

Hemoglobin_____ Hematocrit_____ Platelets_____

1. Diagnosis:_____
2. Allergies:_____

3. Premedicate:
   - ❑ Tylenol 650mg PO
   - ❑ 25 mg Benadry IVP x 1(may give po if pt request)
4. Give:
   - ❑ Lasix ___mg IVP after 1st unit of blood
5. Draw:
   - ❑ Type and Screen/Cross____units(s)
     (Prefer complete one day prior to transfusion)
     (H&H wil be done prior to transfusion)
6. Infuse:
   - ❑ ___unit(s) PRBCs over 2 hours each or as tolerated
   - ❑ ___pack(s) Platelets
   - ❑ ___unit(s) Fresh Frozen Plasma
7. Diet as Tolerated
8. May discharge home after completion of transfusion

Physician Offices−For the most updated form please visit www.coffeeregional.org and print from the "For Our Physicians" link.

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