



BLOOD/BLOOD PRODUCT TRANSFUSION 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 will 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.