FAITH REGIONAL HEALTH SERVICES

OUTPATIENT BLOOD PRODUCT TRANSFUSION ORDER FORM

2700 W. Norfolk Avenue Norfolk, NE 68701 (402) 371-4880

Date Ordered:	Date Patient to be transfused:	Physician	**PATIENT INSTRUCTION: Please bring this form with you to the Hospital Registration Desk.**
Patient Name	Patient Birthdate	Patient Phone Number	

MEDICAL NECESSITY (Sign/Symptoms/Reason for Service) ***Must be completed**

LABORATORY TESTS TO BE DONE:

Type and Crossmatch _____ **Units (Leukoreduced)**
Platelets (apheresis) _____ **Units**
Plasma (FFP) _____ **Units**

Special Handling: Irradiated CMV Neg.

NURSING INSTRUCTIONS

_____ **Transfuse per FRHS Policy** **OR** **Transfuse** _____ **units over** _____ **hours per unit**

PRE-TRANSFUSION MEDICATIONS and / or INSTRUCTIONS

POST TRANSFUSION ORDERS

DISMISSAL ORDERS / INSTRUCTIONS

AUTHENTICATION

_____	_____	_____	_____
Ordering Physician Signature*	**Date**	**Phone**	**Address**

FRHS Staff Physician:

** Please indicate physician responsible for patient during transfusion process.

FOR OFFICE USE ONLY:

☐ Critical Decision Unit Notified ☐ Nursing Supervisor Notified

PLEASE FAX THIS FORM TO THE FRHS LABORATORY AT 402.644.7569

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Patient Label Optional