# BLOOD TRANSFUSION ORDER FORM

**Phone: 903-408-5840**
**Fax: 903-455-8773**

**PATIENT INFORMATION** Date: ____________

Last Name: ______________________ First Name: ______________________ MI: ______

HT: ______ WT: ______ DOB: __________ Sex: ( ) Male ( ) Female SSN: ____________

Street Address: ______________________ City/State/Zip: ______________________

Home Phone #: ____________ Work #: ____________ Cell #: ____________

Allergies: ____________________________________________

**INSURANCE INFORMATION**

**Primary Insurance Name:** ______________________ Insurance Phone #: ____________

Group/Policy Number: ______________________ Employer: ____________

Cardholder Name & SSN: ______________________

**Secondary Insurance Name:** ______________________ Insurance Phone #: ____________

Group/Policy Number: ______________________ Employer: ____________

Cardholder Name & SSN: ______________________

**PHYSICIAN / FACILITY INFORMATION**

Physician's Name: ____________ Contact Name: ____________ Contact Phone #: ____________

Street Address: ______________________ City/State/Zip: ______________________

DEA#: ____________ Phone #: ____________ Fax #: ____________

**STATEMENT OF MEDICAL NECESSITY**

Primary Diagnosis: (ICD–10 Code) ____________ Secondary Diagnosis: (ICD–10 Code) ____________ Date of Diagnosis: ____________

Does the patient have venous access? ❍ Yes ❍ No If Yes, what type? ______________________

**Pre–Meds**

❍ Benadryl: _____ mg ❍ PO ❍ IV ❍ IVP
❍ Acetaminphen: ______ mg ❍ PO ❍ IV ❍ IVP
❍ Lasix: _______ mg ❍ PO ❍ IV ❍ IVP

**Type, Cross match and Transfuse**

**PRBC's:** __________ **Units** ❍ **Leukocyte Reduced**
❍ **Leukocyte Reduced Irradiated**
❍ **Other:** ______________

**Platelets:** __________ **Units** ❍ **Leukocyte Reduced**
❍ **Leukocyte Reduced Irradiated**
❍ **Other:** ______________

Labs Prior to Tranfusion: ____________________________________________

____________________________________________

Labs Post Tranfusion: ____________________________________________

____________________________________________

**Physician's Signature:** ______________________ **Date:** __________ **Time:** __________ **AM/PM**

**Fax completed form to Hunt Regional Infusion Center at (903) 455-8773. PLEASE include copies of ALL patients' current insurance cards to expedite benefit verification. Also, forward any lab work, Letter of Medical Necessity and any other supporting documentation supporting the use of Infusion Therapy.**