LINCOLN Health System

☐ STAT REFERRAL

OUTPATIENT INFUSION CENTER

Phone: 931-438-1100

Fax: 1-931-438-1219

Blood Product Transfusion Order Form

Type and Crossmatch Completed: ___________

Patient name: ________________________________ DOB: ______________ Sex :( ) Male ( ) Female

SSN:______________________ HT: __________ WT: __________ Allergies:____

Street Address____ City/State/Zip ______________________________________

Home Phone #: ___________________________ Work #: ____________________________ Cell #: ___________________________

Insurance Information:

Primary Insurance Name ____ Policy ID #: ______________________________

Secondary Insurance Name____ Policy ID #:______________________________

Physician Information:

Physician's Name:_____________________________ Referral Contact Name: ________________________ Phone: _______________

Address:____City/State/Zip____

DEA#:_____________________________ NPI #:____________________________ Fax #: __________________________________

State License #: __________________________________

Statement of Medical Necessity:

Primary Diagnosis: (ICD-10 Code plus Description)____Date of Diagnosis: ______________

Access: Does the patient have venous access? ☐Yes ☐ No If Yes, what type? ____

Orders:

*****Normal Saline will be used to clear all lines. All MEDIPORTS/PORTS/VAD will be flushed with Heparin and Saline per hospital protocol. *****

☐ Do not administer Heparin to this patient. ☐ Insert PIV ☐ Insert PICC

Type, Crossmatch and Transfuse:

_____Units Leukocyte Reduced PRBCs

_____Units Leukocyte Reduced Irradiated PRBCs

_____Units Leukocyte Reduced Platelets

_____Units Leukocyte Reduced Irradiated Platelets

Pre- medication: All medication x1 unless specified

☐ Benadryl:________________mg ☐ PO ☐ IVP

☐ Acetaminophen:____________mg ☐PO

☐ Lasix:____________________mg ☐PO ☐IVP

☐ Oxygen: ______________________________________

☐ Other: ______________________________________

Plasma: _____Units

Physician's Signature ____**Date**__________________ **Time:**_____________

Fax completed form to the Outpatient Infusion Center at 1 (931) 438-1219.
PLEASE include copies of: H+P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, and CURRENT INSURANCE INFORMATION in order for your referral to be processed.