MATAGORDA REGIONAL
MEDICAL CENTER
MRMC IV THERAPY SERVICES
PHONE: 979-241-5966
FAX: 979-241-5965

☐ **STAT REFERRAL**

BLOOD PRODUCT TRANSFUSION ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ WT: _____ Sex :( ) Male ( ) Female SSN:_____ Home #:_____ Cell#:_____

Street Address_____ City/State/Zip _____

Allergies:_____

INSURANCE INFORMATION

Primary Insurance Name _____ Policy ID #: _____

Secondary Insurance Name_____ Policy ID #:_____

PHYSICIAN / FACILITY INFORMATION

Physician Name_____ Contact Name _____ Contact Phone # _____

Address: _____City/State/Zip_____

DEA#:_____ NPI #:_____ State Lic #:_____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD 10 CODE) Secondary Diagnosis: (ICD 10 CODE)

_____ _____

PERTINENT MEDICAL HISTORY

Does patient have venous access? ☐ **YES** ☐ **NO If yes, what type** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

1) Is the patient incontinent? O Yes O No 2) Is the patient ambulatory? O Yes O No

a) ALL MEDIPORTS/IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL PRN

b) ADMINISTER CATH-FLO 2MG, IVP PER PORT IF PICC LINE BECOMES SLUGGISH OR OCCLUDED; MAY REPEAT AFTER 2HRS IF NEEDED X 1
c) CBC RESULTS MUST BE DRAWN 48 HOURS PRIOR UNLESS MEDICAL NECESSITY CAN BE ESTABLISHED
d) 250 CC BAG OF NORMAL SALINE WILL BE HUNG WITH EVERY TRANSFUSION
e) H+H WILL BE COLLECTED PRIOR TO INITATION OF ALL TRANSFUSIONS

PRESCRIPTION ORDERS

SELECT BELOW	# of UNITS	PRODUCT
		LEUKO REDUCED PRBCs
		LEUKO REDUCRED IRRADITED PRBCs
		LEUKO REDUCED PLATELETS
		LEUKO REDUCED IRRADIATED PLATELETS
		PLASMA

LABS

SELECT BELOW	LAB REQUESTED	WHEN
	BMP	**( ) PRIOR ( ) POST**
	CMP	**( ) PRIOR ( ) POST**
	CBC w/ DIFF	**( ) PRIOR ( ) POST**
	H+H:	**( ) PRIOR ( ) POST**
	Other:	**( ) PRIOR ( ) POST**

PREMEDS

SELECT BELOW	MEDICATION	DOSE	ROUTE
	BENADRYL, PRN		
	ACETAMINOPHEN, PRN		
	OXYGEN		
	Other:		
	Other:		

NOTES/INSTRUCTIONS/COMMENTS

_____
_____
_____
_____
_____
_____

FLUSHES: ***(select all that apply)*** ☐ **10 mL NS Flush Syringe PRN** ☐ **Heparin 500units/5 mL Flush Syringe PRN** ☐ **NS 500 mL PRN**

Physician's Signature _____**Time**_____ **Date**_____

Fax completed form to the MRMC Infusion Center at 979-241-5965.
PLEASE include copies of: H+P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, and CURRENT INSURANCE INFORMATION in order for your referral to be processed.