Adventist Health
Tillamook

Physician Order
Blood Transfusion

*Generic substitute unless checked ☐

ORDERS ARE IN EFFECT UNLESS CROSSED OUT.
Exceptions: Orders preceded by a box (☐) require a ✓ to initiate order.
Orders with blanks indicate additional information is needed.

_________ *Date

_________ *Time

***Patient name:** ______________________________ ***DOB:** ______________

***Diagnosis and ICD-10 code:** ______________________________

Allergies: ______________________________

***Signed by provider, patient and witness:** ☐ **Hospital Consent** ☐ **Blood Transfusion Consent**

Outpatient admit .... ☐ Series ☐ One time

Code status .... ☐ Full code ☐ DNR ☐ Medications only ☐ Other (specify) ______________

Vital signs .... ☐ Per protocol ☐ Other (specify) ______________

Vascular access .... ☐ Port ☐ PICC ☐ CVC ☐ Start SL

***Premeds:** ______________________________

***Type and crossmatch** ______________ units PRBC's

***Transfuse** ______________ units, each over __________ hours PRBC's when blood is ready

Additional orders: ______________________________

____

☐ Discharge patient when blood completed if stable.

______________________________ ______________ ______________
*Physician signature *Date *Time

***Denotes field that must be completed by healthcare worker**

FAX order form and consent(s) to 503-815-7515

Physician Order

Physician Order:
Blood Transfusion
Adventist Health Tillamook
1000 Third St., Tillamook OR 97141

{ Patient label }