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

***Patient name:** _____ ***DOB:** _____

***Diagnosis:** _____

Allergies: _____

_____ *Time

Outpatient admit ..... ☐ Series ☐ One time

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

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

Diet ..... ☐ Regular ☐ Cardiac ☐ Clear liquids ☐ Full liquid
☐ Standard carb/Diabetic (1600-2000 cal)
☐ High carb/Diabetic (2200-2500 cal)

Activity ..... ☐ As tolerated ☐ Other (specify) _____

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

I & O ..... ☐ Yes ☐ No

***Premeds:** _____

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

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

Post transfusion CBC: ..... ☐ Yes ☐ No

Additional orders: _____

_____

☐ Discharge patient when blood completed if stable.

***Healthcare provider's signature:** _____ ***Date:** _____ ***Time:** _____

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

FAX to 503-815-7515

Physician Order Form: Blood Transfusion

Adventist Health Tillamook
1000 Third St., Tillamook OR 97141

{ Patient label }

070-00228 10/22