(Place 2nd Verifier Label Here)
Treatment Room – Central Nursing Station Use only

Northwell Health
Cancer Institute

OUTPATIENT TRANSFUSION ORDER

A. DEMOGRAPHICS:

NAME:______________________ DOB:___/___/___ DATE OF TRANSFUSION:____________

DIAGNOSIS: ____________________________ ALLERGIES:____________________

B. ORDER AND LAB RESULTS:

'RANFUSE AS FOLLOWS:

OF UNITS	TYPE OF TRANSFUSION
	PACKED RED BLOOD CELLS, LEUKOCYTE REDUCED IRRADIATED

LAB RESULTS
DATE:
HGB:
HCT:

# OF UNITS	TYPE OF TRANSFUSION
	SINGLE DONOR PLATELETS

PLATELET PARAMETERS:

Tx if Plt Count ≤ ______

OTHER: ____

C. PREMEDICATION ORDERS- Please indicate the medication/strength and route below:

Drug Name	*Strength*	*Route*	*Prescribe (please check all that apply)*
Acetaminophen	650mg	PO	
Diphenhydramine(Benadryl)	25mg	IVP	
Diphenhydramine(Benadryl)	50mg	IVP	
Diphenhydramine(Benadryl)	25mg	IVPB	
Diphenhydramine(Benadryl)	50mg	IVPB	
Diphenhydramine(Benadryl)	25mg	PO	
Diphenhydramine(Benadryl)	50mg	PO	
Hydrocortisone	50mg	IVP	
Hydrocortisone	100mg	IVP	
Other:			

ther: ______________________________

GNATURE: ______________________________ M.D. / D.O / P.A. / N.P.

RINT NAME: ______________________________ M.D. / D.O / P.A. / N.P.

ATE ORDERED: ____________ TIME ORDERED: ____________