

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX Handwritten forms will not be accepted.

PATIENT INFORMATION		
Name:		DOB:
Allergies:	Date of Referral:	
Diagnosis and ICD 10 CODE		
<input type="checkbox"/> Anemia of chronic renal disease		ICD 10 Code: D63.1
<input type="checkbox"/> Anemia related to chemotherapy		ICD 10 Code: D64.81
<input type="checkbox"/> Anemia unspecified		ICD 10 Code: D64.9
<input type="checkbox"/> Anemia related to blood loss		ICD 10 Code: D50.0
<input type="checkbox"/> Thrombocytopenia		ICD 10 Code: D69.6
REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)		
<input type="checkbox"/> CBC		
<small>*Patient may be required to submit a pregnancy test prior to treatment</small>		
PACKED RED BLOOD CELLS (Check One)		
<input type="checkbox"/> Type and Screen	<input type="checkbox"/> Type and Cross	
Check Desired Product and Indicate Quantity:		
<input type="checkbox"/> Packed cells: ___ # Units	<input type="checkbox"/> Platelets ___ # Units	
Is the patient initiating or receiving Daratumumab (Darzalex) chemotherapy? If so, please contact charge nurse at SBL Infusion Center (Mattoon: 217-258-4150)		
BLOOD PRODUCT ORDERS /TRANSFUSION INSTRUCTIONS		
Date Transfusion Requested: _____	Location of Transfusion: <input type="checkbox"/> Mattoon	
Transfuse each product over ___ hours	Premedication:	
	<input type="checkbox"/> Tylenol 650mg po	
	<input type="checkbox"/> Benadryl 25mg po	
	<input type="checkbox"/> Furosemide 20 mg	
	<input type="checkbox"/> IV one dose prior to infusion	
	<input type="checkbox"/> IV one dose in between units 1 and 2	
	<input type="checkbox"/> Other: _____	
ADDITIONAL ORDERS / INFORMATION		
PRESCRIBER INFORMATION		
Prescriber name :		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:	Date:	Time:

NOTE: In the event of a hypersensitivity reaction during the transfusion, we will implement the reaction protocol. A designated nurse practitioner will evaluate your patient and your office will receive notification of the event.

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:
 Fax Completed Form and all documentation to:

MATTOON
 1000 Health Center Dr. Ph. 217-258-4150
 Suite 204 Fax 217-348-2579
 Mattoon, IL 61938