Referral Status: ☐ New Patient ☐ Updated Patient Information

CMC Infusion Center- Referral Face Sheet

Patient Name: _____ Patient D.O.B._____/_____/_____

Patient Phone # (_____) _____-_____ Gender_____

Patient Address _____

City_____ State _____ Zip Code_____

Referring Provider (Please Print) _____

Office Phone # (_____) _____-_____ Office Contact: _____

Office Fax # (_____) _____-_____

If referring provider and/or patient is external to Conway Medical Center. Please include:

- Most recent history and physical including:
  - Comprehensive medication list
  - Past medical history
  - Related past/ failed therapies (with dates)
  - Known allergies
- Most recent labs / test result (Ex. CBC, PPD, Hepatitis screening, etc.)
- Insurance Information

Please fax requested documentation, face sheet, and treatment plan to **843-234-5460** attention CMC Medication Management Specialist. Please feel free to call 843-234-8575 with any questions.

We look forward to the opportunity to be a part of your patient's treatment journey at Conway Medical Center.

Referral Status ☐ New ☐ Order Change ☐ Order Renewal

Blood and Blood Products Treatment Plan

Patient Name: _____ **Patient DOB** _____/_____/_____

General

☐ Diagnosis-_____ ICD-10 Code _____

Pt. Weight _____ Pt Height _____ Known Allergies _____

Requested Start Date ____/____/_____

IV Access If nothing selected, PIV will be be Utilized

☐ PIV ☐ PICC / Midline / Port

Laboratory

☑ CBC without Diff. If Hgb < 7 or Plts < 15 Infusion Center may redraw CBC to determine stability

Blood, Routine, T;N, Once, CMC Lab

☐ PT

Blood, Routine, T;N, Once, CMC Lab

☐ PTT

Blood, Routine, T;N, Once, CMC Lab

☐ Fibrinogen Lvl

Blood, Routine, T;N, Once, CMC Lab

Pre-Medications

Acetaminophen

☐ *650 mg, Oral, Tab, Day of Tx*
Comments: Administer 30 minutes before transfusion

☐ *1000 mg, Oral, Tab, Day of Tx*
Comments: Administer 30 minutes before transfusion

Diphenhydramine

☐ *25 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before transfusion

☐ *50 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before transfusion

SOLU-Medrol

☐ *40 mg, IV Push, Powder-Inj, Day of Tx*
Comments: Administer 30 minutes before transfusion

Furosemide

☐ *20 mg, IV Push, Injection, Once*
Comments: Infuse at 20 mg/min.

☐ *40 mg, IV Push, Injection, Once*
Comments: Infuse at 20 mg/min.

*** For Hemoglobin less than 6.5 or platelets less than 10, patients will be referred to the Emergency Department for treatment.

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____/_____/_____

Blood and Blood Products Treatment Plan

Special Request

☐ Leukoreduced Other_____

☐ Irradiated

Blood Bank

Red Blood Cells LR

☐ *RT, 1 unit, HgB Low*

☐ *RT, 2 units, HgB Low*

☑ Crossmatch IS

Blood, Routine, T;N, Nurse collect, Order for future visit In Approximately 2-3 days

☑ Type and Screen

Blood, Routine, T;N, Nurse collect, Order for future visit In Approximately 2-3 days, CMC Lab

Fresh Frozen Plasma

☐ *RT, 1 units, Bleed PT Elevated*

☐ *RT, 2 units, Bleed PT Elevated*

☐ *RT, 1 units, Bleed APTT is elevated*

☐ *RT, 2 units, Bleed APTT is elevated*

☐ *RT, 1 units, Bleed INR > 1.5*

☐ *RT, 2 units, Bleed INR > 1.5*

☑ ABO/RH

Blood, Routine, T;N, Nurse collect, Order for future visit In Approximately 2-3 days, CMC Lab

Platelet

☐ *RT, 1 units, Abn. Platelets*

☐ *RT, 2 units, Abn. Platelets*

☐ *RT, 1 units, PLT <50 k Bleed*

☐ *RT, 2 units, PLT <50 k Bleed*

☐ *RT, 1 units, Other _____*

☑ ABO/RH

Blood, Routine, T;N, Nurse collect, Order for future visit In Approximately 2-3 days, CMC Lab

Specify if irradiated needed.

Communication Orders

☐ Communication Order

RN to order Hgb 30 minutes post transfusion

☐ Communication Order

RN to order PTT and PT/INR 30 minutes post transfusion

☐ Communication Order

RN to order Platelet Count 60 minutes post transfusion

☐ Communication Order

RN to order Fibrinogen Level 30 minutes post transfusion

☑ INF Infusion Room Orders Subphase (Month 1 to 12)

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____/_____/_____

RSK-79-FRM
REV 1 04.12.16

Conway Medical Center
Conway, South Carolina

Center Patient Admission Label Here

Informed Consent for Performance of Blood and/or Blood Component Transfusion

Informed Consent is very important to Conway Medical Center. Please carefully read this form and let us know if you have any questions. Please do not sign this form until you understand the risks and alternatives of the procedure and have no questions.
(Initial here_____)

I hereby give my consent and authorize Dr. _____
to order for administration Blood and/or Blood Components at Conway Medical Center.

I acknowledge that:

1. **The nature and purpose of the Blood and/or blood Component transfusion risks involved, alternatives and the possibility of complications have been explained to me by Dr. _____ and that all my questions, if any, have been answered to my satisfaction. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantee has been made as to the results that may be obtained.**

2. **Exceptions to Blood and/or Blood Component Transfusion, if any, are:**
   _____.
   (Note any exceptions or write "None")

3. **My physician has discussed with me the need for and risks of the transfusion of blood and/or blood components and the available alternatives.**

By signing below, I certify that I have had an opportunity to ask the doctor all my questions concerning anticipated benefits, material risks, alternative therapies, and risks of those alternatives, and all of my questions have been answered to my satisfaction.

_____/_____/_____ _____
(Patient or authorized person) (Date) (Time) **(Relationship if authorized person)**

_____/_____/_____ **Reason for authorized person signature**
(Witness) (Date) (Time) ☐ **Minor Patient**
No witness required if patient signature obtained by provider ☐ **Incapacitated patient (form 441 required)**

An interpreter or other special assistance was used to assist patient in completing this form as follows:
☐ Foreign Language (specify) _____ ☐ Sign Language ☐ Patient is blind, form read to patient
☐ Other: (specify) _____ _____
(name of interpreter or service)

CERTIFICATION OF PHYSICIAN:

I hereby certify that I have discussed with the individual granting consent, the nature of the procedure(s), anticipated benefits, material risks, alternative therapies and the risks associated with the alternative of the procedure(s).

_____ _____/_____/_____ _____
Signature of Physician **Date** **Time**