Crystal Run Healthcare
155 Crystal Run Road
Middletown, NY 10941
845-703-6999
www.crystalrunhealthcare.com

FAX COVER SHEET

To: Garnet Infusion

From: Kim Hoeffner

Company:

To Fax Number: 3331902

Fax Reference ID: KHO5F21691A72B7

Date: 7/29/2020 12:18:26 PM

# of pages [incl. cover]: 6

Notes/Comments:

Please Note: Order is STAT. Thank you.

From Fax Number:

Sender Mailing Address: 155 Crystal Run Road

Middletown, NY 10941

Garnet Health MEDICAL CENTER

Outpatient Blood Administration Order Form

Patient's Name Gallo (last) Monica (first) MI Patient's DOB 09/03/1976

Today's date 07/29/2020 Diagnosis Iron deficiency anemia due to chronic blood loss D50.0 Date requested for transfusion STAT

☐ Emergent/life threatening (same day) ☒ Non-emergent (next day)

Instructions to RN: Perform vital signs as per protocol. Hold transfusion and notify physician if patient complains of chills, flank pain, shortness of breath, chest pain, restlessness, infusion site pain or sudden changes in vital signs; order Transfusion Reaction Investigation. **Informed transfusion consent** has been obtained and the patient or health care proxy has been informed of the benefits, risks, and alternatives and has had opportunity to have questions answered. Valid signed consent is valid for 1 year (Fax # 845-333-1902).

Orders for Pretransfusion Tests:

☒ Type and Screen (required for all, valid for 3 days)
☒ CBC (required for red cell and platelet transfusions)
☐ INR/APTT (required for plasma transfusions)
☐ Fibrinogen (required for cryoprecipitate transfusions)

Indications for Special Requirements:
Irradiated: Neonate, Leukemia, Lymphoma, directed donors
CMV Neg: Neonate, CMV Neg transplant candidate/recipient
HgbS Neg: Sickle Cell patients

Rate of Infusion: ☒ 2 Hours for clinically indicated hemodynamically stable patients ☐ 4 Hours
For more information on the rate of infusion refer to policy on Blood Transfusion Administration

Orders for Blood Products:

☐ **1 unit** leukocyte reduced packed red cells — ☐ Irrad ☐ CMV Neg ☐ HgbS Neg
☐ Hemoglobin less than 5 g/dL for sickle cell with congestive heart failure, hypotension, dyspnea.
☐ Hemoglobin less than 7 g/dL with symptomatic chronic anemia, with hematology evaluation or consult.
☐ Hemoglobin less than 7 g/dL with autoimmune hemolysis and cardiopulmonary syndrome.
☐ Hemoglobin less than 8 g/dL with acute cardiopulmonary syndrome
☐ Hemoglobin less than 9 g/dL prior to surgical procedure.
☐ Hemoglobin less than 9 g/dL with cancer, myelodysplastic disorder on chemotherapy.
☐ Hemoglobin less than 10 g/dL with thalassemia to suppress bone marrow.

☒ **2 units** leukocyte reduced packed red cells — ☐ Irrad ☐ CMV Neg ☐ HgbS Neg
☒ Hemoglobin less than 6 g/dL with cancer, myelodysplastic disorder on chemotherapy, or pre-op.
☐ Hemoglobin less than 9 g/dL with thalassemia to suppress bone marrow.

☐ **1 unit** leukocyte reduced apheresis platelets — ☐ Irrad ☐ CMV Neg
☐ Prophylactic correction of platelet count of less than 10,000 if at risk of hemorrhage.
☐ Active hemorrhage or pre-op for platelet count of less than 50,000.
☐ Correction due to anti-platelet agent for active hemorrhage or pre-operative.

☐ **1 unit** plasma
☐ INR greater than 2.0 prior to an invasive procedure, 1 unit at a time until corrected.
☐ INR greater than 1.5 for active hemorrhage, 1 unit at a time until corrected.
☐ Documented coagulation factor deficiency, 1 unit at a time only if clotting factor not available.
☐ Hereditary angioedema treatment, 1 unit at a time until symptoms relieved.

☐ **1 dose** cryoprecipitate
☐ Fibrinogen less than 100 mg/dL
☐ Fibrinogen less than 150 mg/dL with active hemorrhage.
☐ Uremic bleeding when alternatives cannot control hemorrhage.

Orders for Pre-Transfusion Medication:

☐ Furosemide (Lasix) 20 mg IV, once ☐ Diphenhydramine (Benadryl) 25 mg capsule, oral, once
☒ Diphenhydramine (Benadryl) 25 mg IV, once ☒ Acetaminophen (Tylenol) 650 mg tablet, oral, once
☐ Hydrocortisone (Solu-Cortef) 100 mg IVPB, once

Ordering Physician's Name (print) Dr. Gurvinder Sethi Physician's phone 845-615-6999
Ordering Physician's Signature [signature] Date 07/29/2020

Fax completed order to Garnet Health Medical Center Infusion Center (845-333-1902) and Blood Bank (845-333-0137)

Rev 12/2018, 4/29/2019

Crystal Run Healthcare Physicians LLP

155 Crystal Run Road
Middletown, NY 10941-4028
USA
(845) 703-6999

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
Gallo, Monica C	533012	###-##-0336	09/03/1976	English	F

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)	ETHNICITY
PO Box 413	824 Route 32	Hispanic Or Latino

CITY, STATE ZIP	HOME PHONE	CITY, STATE ZIP	SECONDARY HOME PHONE	RACE
Highland Mills, NY 10930	(845) 273-1173	Highland Mills, NY 1...		Declined to speci...

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN	CONTACT NAME	CONTACT HOME PHONE
Rahman MD, Andreea	Rahman MD, Andreea		

SEXUAL ORIENTATION	PREFERRED PRONOUN	GENDER IDENTITY	

PRIMARY EMPLOYER	SECONDARY EMPLOYER (If Applicable)
Tumi	
ADDRESS	ADDRESS
328 Red Apple Ct, Woodbury Common	
CITY, STATE ZIP	CITY, STATE ZIP
Central Valley, NY 10917	
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)
CITY, STATE ZIP	CITY, STATE ZIP
HOME PHONE	SECONDARY HOME PHONE
RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY#
BCBS Local Suitcase Out Of Area Bluecard	JCH828521180
NAME OF INSURED	GROUP#
Gallo, Shane K	
ADDRESS OF INSURANCE COMPANY	COPAY AMT
PO Box 3877, Church Street Station	$0.00
CITY, STATE ZIP	DEDUCTIBLE
New York, NY 10008-3877	$0.00
RELATIONSHIP TO PATIENT	EFFECTIVE DATE / EXPIRATION DATE
Parent, Child Is the Patient	

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY	POLICY#

NAME OF INSURED	SSN#	BIRTHDATE	GROUP#

ADDRESS OF INSURANCE COMPANY	COPAY AMT
CITY, STATE ZIP	DEDUCTIBLE
RELATIONSHIP TO PATIENT	EFFECTIVE DATE / EXPIRATION DATE

*All returned checks are subject to a $25.00 check fee.

I authorize the release of any medical or other information necessary to process claims. I also authorize government benefits to the provider who accepts assignment and authorize payment to the physician/supplier for services provided. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

Insurance Card - Gallo, Shane K

Front:

BlueCross BlueShield

Johnson Controls

Subscriber Name:
SHANE K. GALLO
Identification Number:
JCH828521180

Group Number: 191274

RxBIN: 003858 RxGRP: JCI4RXS
RxPCN: A4

Blue Edge® PPO

Back:

www.bcbsil.com

[redacted]

BlueCross BlueShield of Illinois

Pre-notification: Call one day before inpatient or skilled nursing facility admission, receiving home health care or private duty nursing services, and within two days of an emergency, maternity or for a mental health/substance abuse admission. Provider: File medical claims with your local BCBS Plan.

Customer Service	1-888-541-7927
Pre-Notify Med	1-888-541-7927
Pre-Notify MH/SA	1-888-541-7927
Provider Locator	1-800-810-2583
24/7 Nurseline	1-800-299-0274
MDLive	1-888-676-4204
RX MemberService*	1-844-648-9629
TreatmentSupport*	1-888-361-3944

mdlive.com/jci
*Group contracts directly

BlueCross BlueShield of Illinois, an independent licensee of the BlueCross BlueShield Association, provides claims processing only and assumes no financial risk for claims.

Crystal Run Healthcare Physicians LLP

Gallo, Monica C
PO Box 413
Highland Mills, NY, 10930
Person #: 788405
Sex: F
DOB: 09/03/1976

Order Date: 07/13/2020

Ordering: Yang MD, Ying **Location:** Newburgh (Route 300)

Tests Ordered : CBCA XT (CBCA XT), CBC With Auto Diff (CBCA), Complete Metabolic Profile (CMP) (CMP), Magnesium (MG)

CBCA XT (Collection Date: 07/27/2020 12:34, Status: Final)

Component	Result	Units	Flag	Range	Comment
NRBC#	0.00	K/uL			
NRBC%	0.0	%			
XT Baso#	0.04	K/uL		0.00-0.20	
XT Baso%	0.8	%		0.0-1.5	
XT Eo#	0.05	K/uL		0.00-1.10	
XT Eo%	0.9	%	L	1.0-10.0	
XT HCT	20.6 Repeated and Verified	%	LL	35.0-47.0	Critical result emailed to Dr Yang 3mins on 7/27/2020 at 5:58 PM by Rios, Kaitlyn
XT HGB	5.9 Repeated and Verified	g/dL	LL	11.7-15.7	Critical result emailed to Dr Yang 3mins on 7/27/2020 at 5:58 PM by Rios, Kaitlyn
XT IG#	0.02	K/uL		<=0.10	
XT IG%	0.4	%		<=1.0	
XT Lymph#	1.51	K/uL		0.60-4.00	
XT Lymph%	28.3	%		15.0-45.0	
XT MCH	18.5	pg	L	26.0-33.0	
XT MCHC	28.6	g/dL	L	32.0-36.0	
XT MCV	64.6	fL	L	80.0-97.0	
XT Mono#	0.5	K/uL		0.1-1.2	
XT Mono%	9.0	%		1.5-9.0	
XT MPV	10.9	fL		7.0-11.0	
XT Neut#	3.2	K/uL		1.5-8.1	
XT Neut%	60.6	%		41.0-74.0	
XT PLT	317	K/uL		140-440	
XT RBC	3.19	m/uL	L	3.80-5.20	
XT RDW-SD	45.6	fL			
XT WBC	5.3	K/uL		3.5-11.0	

Magnesium (Collection Date: 07/27/2020 12:34, Status: Final)

Component	Result	Units	Flag	Range	Comment
Magnesium	1.9	mg/dL		1.6-2.3	

CMP (Collection Date: 07/27/2020 12:34, Status: Final)

Component	Result	Units	Flag	Range	Comment
Albumin	3.8	g/dL		3.5-5.0	
ALP	46	U/L		28-109	
ALT	9	U/L		3-60	
AST	15	U/L		4-60	
BUN	8	mg/dL		7-17	
Calcium	8.9	mg/dL		8.5-10.4	
Chloride	103	mmol/L		98-109	
CO2	27	mmol/L		22-30	
Creatinine	0.7	mg/dL		0.5-1.1	
eGFR	90.9	mL/min/1.73m2		>=60.0	eGFR NON AFRICAN AMERICAN
eGFRAA	110.2	ML/MIN/1.73m2		>=60.0	eGFR AFRICAN AMERICAN
Glucose	83	mg/dL		65-105	
Potassium	4.1	mmol/L		3.5-5.2	
Sodium	139	mmol/L		136-145	
Total Bili	0.3	mg/dL		<1.3	
Total Protein	6.9	g/dL		6.2-8.2	