UPDATED SCHEDULING SHEET FOR OUTPATIENT MEDICAL

420 Lowell DR., Suite 500 (Professional Tower) 256-265-3058

Scheduler's Name and Phone Number_____

Today's Date/Time_____

Patient's Name_____DOB_____

Ht._____ Wt._____ Allergies_____

Pregnant: No_____ Yes_____ How many weeks_____ Lactating: No_____ Yes_____

Patient's Phone # (C)_____ (H)_____

Social Security #_____

Insurance_____Policy #_____

PCP Referral # _____
(Must have this if patient has Medicaid "Patient First." If MD office does not have this referral #, tell them to get it and fax to us ASAP).

Procedure_____Diagnosis _____

Ordering Physician _____

Date Scheduled_____ Time Scheduled_____

Will this patient's drug be sent to HH from a specialty pharmacy? No_____ Yes_____ If "yes" has the drug order been placed with the specialty pharmacy? No_____ Yes_____

Does pt. have a central line? No_____ Yes_____ What kind: PICC____PortaCath____Hickman_____
Other_____

Is patient ambulatory? Yes_____ No_____ If "no" someone may be asked to stay with patient.

Any special needs? No_____ Yes_____ If "yes" explain_____
Will they need an interpreter? No_____ Yes_____ What language?_____

For All Orders: Make sure physician "signs, dates, and times" all orders. Diagnosis, Ht., Wt., DOB, allergies, and pregnancy and lactation status (if applicable) must be written on order.

For Blood Transfusions: Type & Crossmatch done? Yes_____ No_____ On order sheet include: RBAs discussed with pt. If T & XM done remind them to tell pt. to keep armband on.

If patient is to stay for an extended time remind them to bring lunch or snack if needed.

Instruct Scheduler to fax completed order to (256) 265-3074

PHYSICIAN'S ORDERS

PHYORD

HUNTSVILLE HOSPITAL HEALTH SYSTEM — **HUNTSVILLE, ALABAMA**

Plan Selection Display: INF Outpatient Blood Administration
Available at: Outpatient Medical Services

Diagnosis and ICD-10 code _____

Weight (kg) _____ **Height (cm)** _____ **Allergies** _____

Benefits, risks and treatment alternatives of blood products have been discussed with patient

☑ **Permit/Authorize - Obtain Blood administration consent form**

RBCs ☐ Add Units on previous Sample ☐ Type and Crossmatch Adult ☐ Type and Screen ☐ ABO/Rh Type

☐ Stat ☐ Routine _____ units Transfuse over _____ hrs/unit

Must pick one Transfuse Reason:
☐ HCT<21/HGB 7.0 – PT with stable volume ☐ HCT<24/HGB 8.0 – PT with stable volume ☐ Emergent
☐ Immunodeficiency Syndrome ☐ Bone Marrow & stem cell recipient ☐ Anticipation of blood loss
☐ Falling HCT in PT with unstable volume

Special request: ☐ Autologous ☐ CMV Neg ☐ Directed ☐ Fresh ☐ Irradiated ☐ Leukopoor

Sickle Cell Status: ☐ Negative for sickle cell anemia ☐ Patient has Sickle Cell Anemia ☐ Patient has Sickle Cell Trait
☐ Patient is not able to respond ☐ Sickle cell status not known

Platelets ☐ Stat ☐ Routine _____ units

Must pick one Transfuse Reason:
☐ Plt count < 10,000/uL (<10k) ☐ Bleeding with plt count < 80,000/uL ☐ Bleeding - abnormal Platelet Function
☐ Bleeding - known thrombocytopenia ☐ Immunodeficiency Syndrome ☐ Bone Marrow & stem cell recipient
☐ Operative bleed with PLT < 100,000/uL ☐ Massive blood transfusion

Special request: ☐ CMV Neg ☐ Crossmatched ☐ HLA Matched ☐ Irradiated ☐ Platelet Concentration

☐ **Fresh Frozen Plasma** ☐ **Cryoprecipitate**
☐ Stat ☐ Routine _____ units Transfuse Reason: Symptomatic coagulopathy

Give Pre-Medication 15-30 mins before beginning the infusion
☐ **acetaminophen (Tylenol DoT)** _____ mg, Oral, Tab, Day of Tx
☐ **diphenhydrAMINE (Benadryl DoT)** _____ mg, Oral, Cap, Day of Tx
☐ **methylPREDNISolone (SOLU-Medrol DoT)** _____ mg, IV Push, Injection, Day of Tx
☐ **furosemide (Lasix DoT)** ____mg, IV Push, Injection, Day of Tx ☐ **End of transfusion** ☐ **After 1st unit**
☐ Saline Lock
☑ INF Central and Peripheral Flush Orders OUTPATIENT

Physician's Sig: **Trans#:** **Date:** **Time:**

Patient Name:

DOB: