



Type and Crossmatch Completed: _____

Patient name: _____ DOB: _____ Sex : () Male () Female
 SSN: _____ HT: _____ WT: _____ Allergies: _____
 Street Address _____ City/State/Zip _____
 Home Phone #: _____ Work #: _____ Cell #: _____

Insurance Information:

Primary Insurance Name _____ Policy ID #: _____
 Secondary Insurance Name _____ Policy ID #: _____

Physician Information:

Physician's Name: _____ Referral Contact Name: _____ Phone: _____
 Address: _____ City/State/Zip _____
 DEA#: _____ NPI #: _____ Fax #: _____
 State License #: _____

Statement of Medical Necessity:

Primary Diagnosis: (ICD-10 Code plus Description) _____ Date of Diagnosis: _____

Access: Does the patient have venous access? Yes No If Yes, what type? _____

Orders:

***Normal Saline will be used to clear all lines. All MEDIPOINTS/PORTS/VAD will be flushed with Heparin and Saline per hospital protocol. ***

- Do not administer Heparin to this patient.
- Insert PIV
- Insert PICC

Type, Crossmatch and Transfuse:

____ Units Leukocyte Reduced PRBCs
 ____ Units Leukocyte Reduced Irradiated PRBCs
 ____ Units Leukocyte Reduced Platelets
 ____ Units Leukocyte Reduced Irradiated Platelets

Pre-medication: All medication x1 unless specified

- Benadryl: _____ mg PO IVP
- Acetaminophen: _____ mg PO
- Lasix: _____ mg PO IVP
- Oxygen: _____
- Other: _____

Plasma: ____ Units

Please select one of the following:

- Infuse at: _____ mL/hr
- Infuse per HH Lincoln Health Blood Administration Protocol

Physician's Signature _____ **Date** _____ **Time:** _____

Fax completed form to the Outpatient Infusion Center at 1 (931) 438-1219.
PLEASE include copies of: H+P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, and CURRENT
INSURANCE INFORMATION in order for your referral to be processed.