Blood Transfusion Center
Check List

Patient Name: ______________________________ DOB__________________

☐ Demographic Sheet
☐ History and Physical dated within the past 30 days (60 days for nursing home residents)
☐ Mobility
 ☐Independent, no assistive devices
 ☐Hoyer lift/bed bound
 ☐Other, describe ____

☐ Infection control
 ☐None
 ☐MRSA
 ☐VRE
 ☐Other (describe)____

☐ Dietary restrictions
 ☐None
 ☐Restrictions (specific orders required on Patient Care Order Sheet)

☐ Indwelling catheters, drains, or airways.________________________________
(specific orders required on Patient Care Order Sheet)

☐ Toileting regimen:____

☐ Special communication NEEDS:____

☐ Hematocrit dated within the past 7 days (faxed)

☐ Current medication list
 ☐Institution list attached
☐ Code status
 ☐Full
 ☐DNR (must include copy of signed DNR/ advanced directives)
 ☐Other, describe ____

☐Ventilator dependant (respiratory therapist must accompany)

☐Oxygen therapy (must be written on Patient Care Order Sheet)

☐Patient care orders Signed and dated including any additional therapies/medications during their stay.

☐Consent for blood transfusion dated and **signed by physician, and patient or patient guardian**.

☐MD/NP/PA to call for clarification and emergency ______________________________________
Telephone number ____________________ Pager # ______________