APPALACHIAN
Regional Healthcare System
Seby B. Jones Regional Cancer Center

Patient Name________________________________
Date of Birth________________________________
Phone Number________________________________
Please Fill in or Affix a Patient Label

Seby B. Jones Regional Cancer Center Non-Oncology Infusion Service

Transfusion Request

Diagnosis: ____ (ICD-10: ____________________)

Product:

☐Red blood cells (PRBCs)

Number of units: _________________

_____ Type and Crossmatch (required)

☐Platelets

Number of units: _________________

☐Other; please specify: ____

Pre-Medications:

☐Tylenol 650 mg PO once

☐Benadryl 25 mg PO once

☐Other; please specify: ____

Additional orders (*including labs*):

____

____

____

____

Physician Signature: ___________________________________ Date: _____________ Time: ________

Name of Provider (printed): ____

Emergency Provider Contact Number: ____

Effective Date: 11/11/2016
Revised Date: 12/01/2016
Form Number: 11167

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