***Generic Substitute Unless Checked ❑**

ORDERS ARE IN EFFECT UNLESS CROSSED OUT
EXCEPTIONS: ORDERS PRECEDED BY A BOX (❑) REQUIRE A ✓ TO INITIATE ORDER
ORDERS WITH BLANKS INDICATE ADDITIONAL INFORMATION IS NEEDED

	* Patient Name	* Date of Birth
* Date	* Diagnosis	
	Allergies	
* Time	Outpatient Admit ❑ Series ❑ One Time	
	Code Status ❑ Full Code ❑ DNR ❑ Medications Only ❑ Other (SPECIFY)	
	Vital Signs ❑ Per protocol ❑ Other (SPECIFY)	
	Diet ❑ Regular ❑ Cardiac ❑ Clear Liquids ❑ Full Liquid ❑ Standard Carb/Diabetic (1600 – 2000 cal) ❑ High Carb/Diabetic (2200 – 2500 cal)	
	Activity ❑ As tolerated ❑ Other (SPECIFY)	
	Vascular Access ❑ Port ❑ PICC ❑ CVC ❑ Start SL	
	I & O ❑ Yes ❑ No	
	* Premeds	
	* Type and Crossmatch ___________ units PRBC's	
	* Transfuse __________ units, each over __________ hours PRBC's when blood is ready	
	* Post transfusion CBC ❑ Yes ❑ No	
	Additional Orders ______________________________	
	❑ Discharge patient when blood completed if stable	
	* Healthcare Provider's Signature ______________________________	

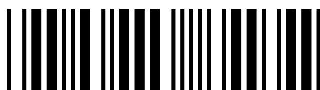
- * Denotes field that must be completed by Healthcare worker

Fax to 503-815-7515

Tillamook Regional Medical Center – Adventist Health

Physician Order Form-Blood Transfusion

Outpatient Therapy Services



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Physician Order Form

106314G Rev. 05/2012

[Patient Label]