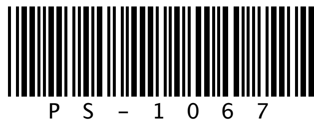
DeKalb Medical
Tax ID Number 58-1966795



P S - 1 0 6 7

DTC Blood Transfusion Order
FAX orders to: 404.501.5703
Phone: 404.501.5580

Patient Information (Required for Scheduling)

Patient Name: ______________________ DOB: ______________ Sex: ❑ M ❑ F SS#: XXX-XX-_____
First & Last Name

Patient's Address: ______________________ ______________ ______ ______
Street City State Zip Code

Home Phone #: ______________ Mobile Phone #: ______________ Email Address: ______________________

Primary Insurance: ______________________ Policy #: __________ Group #: ________ Insurance Phone #: ____________
Plan & Product

Secondary Insurance: ______________________ Policy #: __________ Group #: ________ Insurance Phone #: ____________
Plan & Product

Order Information – Blood Transfusion

Diagnosis: ____

ICD CM Codes: ____

Test/Service: ____

CPT Codes: ____

Hgb:____________ Hct:______________ Platelets:______________ PT/INR________________

1. Type and Crossmatch ______ units of packed cells , _______ units of platelets, _______ units of fresh frozen plasma and transfuse

2. Pre med with Benadryl 25 mg ☐ PO or ☐ IV
   Tylenol 650 mg PO
   Other______________________________

3. Give Lasix ________mg ☐ after first unit or ☐ after second unit

4. Additional orders:

Referring Physician Information

Physician Name (first & last): ______________________ NPI#: ____________ GA License #: ____________

Physician Address: ______________________ Phone #: ____________ Fax #: ____________

I hereby certify that the services indicated in the above order form are medically necessary.

Physician Signature: ______________________ **Date:** ____________ **Time:** ____________