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 # ________________