Wickenburg Community Hospital

PATIENT LABEL

Boyd Infusion Center-Medication Order

Phone: 928-668-5500
Infusion Center Fax: 928-668-1816
Pharmacy Fax: 928-684-5499

Date of order: _____ Ordering Provider: _____

Patient Name: _____ DOB: _____

Diagnosis: _____ **Diagnosis Code: _____**

Medication: _____

_____

Frequency of medication:
Repeat every _____for a total of _____ number of doses

Pre-medications:
Solumedrol _____mg IV ____ po _____
Benadryl _____ mg IV ____ po _____
Tylenol _____ mg po
Other Med: _____ _____mg IV ____ po _____

Draw labs: (type and frequency) _____

May draw from PORT: yes _____ no _____
If the patient has no Central Access, please fax lab draw order to WCH Registration at 928-684-9164

Additional orders (e.g. port flush, Hydration, dressing change, urinary catheter change, etc. – see separate order form for blood transfusions)

_____

_____

___ Current H & P or current office notes
___ Current Labs or test results (e.g. DEXA scan)
___ Patient Allergy List
___ Patient Data Sheet

X _____
Signature of Ordering Provider

X _____
Signature of Supervising Provider, if needed

Phone number _____ Fax number _____

click and enter Dept. # and Date

Wickenburg Community Hospital

PATIENT LABEL

Boyd Infusion Center- Blood Products Order

Phone: 928-668-5500
Infusion Center Fax: 928-668-1816
Pharmacy Fax: 928-684-5499

Start Date of order: _____ End Date of order: _____

Ordering Provider: _____

Patient Name: _____ DOB: _____

Diagnosis: _____ **Diagnosis Code: _____**

_____ Draw CBC (if not done at WCH within past 24 hrs)
_____ Draw Blood Bank Specimens and band the patient
_____ Type and Crossmatch for Hgb < or = to _____

Draw additional labs: (type and frequency) _____
May draw from PORT: yes _____ no _____

- **If the patient has no Central Access, please fax lab draw order to WCH Registration at 928-684-9164**

Order to Transfuse:
Transfuse _____ Units Packed Red Blood Cells for Hgb of _____
Specify if necessary: ____ Irradiated PRBC's ____ CMV Negative

Transfuse _____ Units Single Donor Platelets on _____ date for _____ (Parameters to transfuse)
Transfuse _____ Units FFP on _____ date

Frequency for repeated CBC, Type & Cross Match and orders to transfuse according to the indicated parameters:
_____

Pre-medications:
Solumedrol _____mg IV ____ po _____
Benadryl _____ mg IV ____ po _____
Tylenol _____ mg po
Other Med: _____ _____mg IV ____ po _____

Additional orders (e.g. port flush, Hydration, dressing change, urinary catheter change, etc):
_____

_____

___ Current H & P or current office notes
___ Current Labs or test results (e.g. DEXA scan)
___ Patient Allergy List
___ Patient Data Sheet

X _____
Signature of Ordering Provider

X _____
Signature of Supervising Provider, if needed

Phone number: _____ Fax number: _____

click and enter Dept. # and Date