LAWRENCE COUNTY
Memorial Hospital
DEACONESS ILLINOIS PARTNER

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

DIAGNOSIS AND ICDE 10 CODE	
☐ Erythropoietin Deficient Anemia	ICD-10 Code: D63.1
☐ Anemia related to chemotherapy	ICD-10 Code: D64.81
☐ Anemia unspecified	ICD-10 Code: D64.9
☐ Anemia related to blood loss	ICD-10 Code: D50.0
☐ Thrombocytopenia	ICD-10 Code: D69.6
☐ Anemia in chronic renal disease	ICD-10 Code: N18.9
☐ Other:_____	ICD-10 Code: _____

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ The signed order form by the provider ☐ Patient demographics AND insurance information ☐ Prior authorization with reference number *Pt may be required to submit a pregnancy test prior to treatment	☐ Clinical/Progress notes (must be within 1 year) ☐ Labs and Tests supporting primary diagnosis ☐ CBC

PACKED RED BLOOD CELLS/ PLATLETS (Check One)

☐ Type and Screen ☐ Type and Crossmatch

Check desired product and indicate quantity:
☐ Packed Cells: _____ # Units ☐ Platelets: _____ # Units

Is patient initiated or receiving Daratumamab (Darzalex) chemotherapy? ☐ Yes ☐ No

FRESH FROZEN PLASMA (FFP) — INDICATION AND ICD-10 CODE

Indication (check all that apply)	**ICD-10 Code**
☐ Coagulopathy / Coagulation Factor Deficiency	D68.9
☐ Disseminated Intravascular Coagulation (DIC)	D65
☐ Warfarin / Anticoagulant Reversal with Bleeding	T45.515A
☐ Liver Disease with Coagulopathy / Bleeding	K76.0 + D68.4
☐ Massive Transfusion Protocol (MTP)	T79.4XXA
☐ TTP / Plasma Exchange	M31.1
☐ Hereditary Factor Deficiency (non-hemophilia)	D68.2
☐ Other: _____	ICD-10 Code: _____
☐ **FFP Units Ordered: _____ # Units**	**ABO Type Confirmed: ☐ Yes ☐ No**
☐ Type and Screen ☐ Type and Crossmatch	

BLOOD PRODUCT ORDERS		
Date Transfusion Requested: _____ Transfuse each product over _____ hours		
PREMEDCATIONS		
□ Acetaminophen 650mg PO □ Diphenhydramine 25mg PO □ Furosemide 20mg □ IV one dose after transfusion □ IV one dose between units 1 and 2 □ Other: _____		
ADDITIONAL ORDERS/ INFORMAITON		
PRESCRIBER INFORMATION		
Provider Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

ALL INFORMATION COUNTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515
FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

INFUSION ORDERS –BLOOD TRANSFUSION