NEW YORK STATE DEPARTMENT OF HEALTH Bureau of Emergency Medical Services Blood and Tissue Resources Program

Blood Transfusion Transfer Orders

Patient Name (Print)		DOB		
Patient ID		Date		
Transferring Hospital Name	Receiving Hospital Name	2		
Continue PRBC Other	a	t	mL/hr	
Also Administer:			# Units	Rate (mL/hr)
□ PRCBs				
Other:				
Special Instructions:				
Ordering Physician: PRINT NAME	SIGNATUR	Ε		
	PHONE NU	IMDED		
	PHONE NO	JMBEK		
SECTION BELOW TO BE COMPLETED BY AMBULANCE TRANSFUSION SERVICE I	PERSONNEL			
Ambulance Service: PRINT NAME				
		. .		
NYS-EMS ID #: PRINT NAME	PC	.R#:		
Remarks:				