NEW YORK STATE DEPARTMENT OF HEALTH

Blood and Tissue Resources Program

Bureau of Emergency Medical Services

Blood Transfusion Transfer Orders

Patient Name: _____ **DOB:** _____

Patient ID#: _____ **Date:** _____

_____ _____

Transferring Hospital Name **Receiving Hospital Name**

☐ Continue: ☐ PRBC ☐ Other _____ at _____ mL/hr

Also Administer:	# Units	Rate (mL/hr)
☐ **PRBCs**		
☐ **Other:**		

Special Instructions: _____

_____

_____

_____

Ordering Physician: _____ _____

Print Name Signature

( ) - _____

Phone Number

SECTION BELOW TO BE COMPLETED BY AMBULANCE TRANSFUSION SERVICE PERSONNEL

Ambulance Service: _____

Print Name

NYS-EMS ID No.: _____ **PCR #:** _____

Remarks: _____