

SHORT FORM FOR INFUSION/TRANSFUSION PRIVILEGES

Last Name _____ First Name _____

Office Address _____

Office Telephone _____ Fax _____ E-mail Address _____

SPECIALTY: _____ OHIP BILLING NO. _____

College Registration No.(CPSO/CNO) _____

Malpractice Insurance No. (CMPA/CNPS/Other) _____

The above named Physician/Nurse Practitioner (NP) is requesting limited privileges for the purpose of ordering in -hospital infusions/transfusions of blood products at the Perth and Smiths Falls District Hospital.

I acknowledge I have read and am in agreement with the terms and conditions as laid out below.

Signature _____ Date _____

Please return application to Katie McMillan at katie.mcmillan@psfdh.on.ca
or by fax at 613-267-7198.

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Please note, and mark (x) as appropriate, respecting the following documents which need to be submitted to the Perth Smiths Falls District Hospital

- ___ Two letters of reference
OR
___ Written recommendation of a Full-Time Member of PSFDH Medical Staff
OR
___ Proof of Membership in Good Standing of a Hospital/CCHC

___ Proof of current malpractice insurance(CMPA/CNPS) (please include a copy)
___ Proof of current licensure with the CPSO/CNO (please include a copy)

Please Note: Changes in any above item must be reported, in writing, to the Chief of Staff at the PSFDH by the Physician/NP involved.

Below is the understanding of the role you, as the Physician/NP ordering the infusion/transfusion of a blood product, undertakes, and the role and responsibility of the PSFDH.

Role & responsibility of the ordering physician

*Note: we would **STRONGLY** recommend the completion of the free educational programme: **Bloody-Easy Lite** sponsored by ORBCON, the Ontario Regional Blood Coordinating Network. It can be found at: belite.transfusionontario.org/*

This is “an electronic learning tool providing practical information about transfusion medicine. It is designed to enhance the ability of physicians and health care professionals to use blood and its alternatives knowledgeably, and to recognize and manage adverse consequences of transfusion.”

- 1) Determine the need for a blood product. [Please note, in the majority of instances, a restricted transfusion policy is superior to a more liberal one. The recommended threshold for the vast majority of transfusion needs is 70 gm/l. IF a transfusion is being requested for the patient whose Hgb is greater than 70, the reason for such needs to be indicated with the order. It will be subject to review.]
- 2) Obtain an informed *Consent to Receive Blood Components Form** from the patient, or POA if patient incompetent. This is valid for one year. Informed consent requires the patient or designate has read and understood the *Transfusion for Patients and their Family* booklet* before signing the consent form. **An infusion/transfusion will not be given without a valid consent.**
- 3) Fax the patient’s CBC (valid within last 7 days), completed consent form* and the *Medical Day Care Referral Form* (order sheet)* to 613-267-2041. Please note a separate and specific MOHLTC *IVIG Form** is needed for IVG.
- 4) Patients must have a valid Ontario Health Insurance Number to be registered.
- 5) It is strongly recommended, especially for the first infusion, the patient be accompanied home.

***To download forms:** go to: psfdh.on.ca, select care and service tab then select medical day care unit, forms at bottom of page.

Role & responsibility of the PSFDH

- 1) Upon receipt of a copy of a signed consent and the Physician's/NP's order, the patient will be contacted to arrange an appointment time. Your office will be notified if contact information is missing, or the patient could not be reached. Appointments will be made directly with the patient not through the Physician/NP office. We will do our best to accommodate short notice treatments but may not always be able to do so depending on patient volumes.
- 2) Upon arrival, the patient will be registered using a valid OHIP card.
- 3) The patient will be infused/transfused as per the pre-received infusion/transfusion order.
- 4) The patient will be receiving our standard exemplary care throughout their time in our hospital- both routine and emergent in the instance of any complications. Lunch will be provided if the patient is with us over the lunch period
- 5) Please note: if there are concerns regarding the patient's fitness to receive an infusion/transfusion, the infusion/transfusion may be cancelled or modified as judged necessary by hospital nursing and/or medical staff.
- 6) The ordering Physician/NP will receive a copy of the infusion/transfusion summary from our Health Records Department.
- 7) This is an ambulatory clinic that supports stable out-patients with non-urgent treatment needs to be able to transfer independently, toilet themselves and be able to
 - tolerate sitting for the duration of their treatment. For those less independent a caregiver/family member must be in attendance.

For use by Credentials Committee at PSFDH.

____ CPSO/CNO confirmation received

____ Proof of Malpractice Insurance received

Chief of Staff, PSFDH

Date

President & CEO, PSFDH

Date