



Blood Product Transfusion

Patient and Physician Information

Patient Name:	Date of Birth:	Patient Phone Number:
Physician Name:	Office Phone Number:	Fax Number:
Insurance:	Group Number:	Policy Number:
Hospitalization Status:	Patient Weight (kg):	Height (inches):
<input checked="" type="checkbox"/> Outpatient to Outpatient Infusion Center		
Allergies:		

Send patient demographics/insurance, clinical notes, and test results with orders

Diagnosis Code/Description for treatment:

- Lab History from last 7 days: Hemoglobin/Hematocrit _____ Platelet Count _____
 ► Type and Crossmatch (prior to appointment), Date Completed: _____

Laboratory

- ☐ TYPE AND SCREEN ☐ SICKLE SCREEN ☐ FERRITIN (827278)

Premedication

- ☐ Diphenhydramine (Benadryl) 25 MG ORAL ONCE
☐ Diphenhydramine (Benadryl) 50 MG IV PUSH ONCE (J1200 : 50 MG = 1 unit)
☐ Acetaminophen (Tylenol) 325MG 2 TAB ORAL ONCE
 Other: _____

Medications

- ☒ Normal Saline 0.9% Solution 20 milliliter/hour INTRAVENOUS (J7050 : 250 ML = 1 unit)
☐ Furosemide (Lasix) 20 MG INTRAVENOUS ONCE between units (J1940 : 20 MG = 1 unit)

Orders

Packed Cells _____ **UNIT(s) (P9016)** **Rate:** _____

Reason for Transfusion: _____

- ☐ Hemoglobin LESS THAN or EQUAL to 7 g/dL OR Hematocrit LESS THAN or EQUAL to 21%
☐ Hemoglobin LESS THAN or EQUAL to 8 g/dL OR Hematocrit LESS THAN or EQUAL to 24% in a patient with Coronary Artery Disease AND unstable angina/ myocardial infarction/ cardiogenic shock
☐ Acute Blood Loss GREATER THAN 30% of estimated blood volume, not responding to appropriate volume resuscitation, or with ongoing blood loss
☐ Tachycardia, HYPotension NOT corrected by adequate volume replacement
☐ Blood Disorder with Malaise ☐ Blood Disorder with Fatigue ☐ Sickle Cell

Special Needs ☐ Autologous ☐ CMV Negative ☐ Directed Donor ☐ Irradiated ☐ HGB S NEG ☐ Washed

Pheresis Platelets-Leukocyte Reduced _____ **BAG(s) (1 equivalent to 6 platelets) (P9035)** **Rate:** _____

Reason for Transfusion: _____

- ☐ Platelet count LESS THAN or EQUAL to 10,000 for patient with failure of platelet production
☐ Platelet count LESS THAN or EQUAL to 20,000 AND petechiae
☐ Platelet count LESS THAN or EQUAL to 50,000 AND hemorrhage
☐ Platelet count LESS THAN or EQUAL to 50,000 AND invasive procedure
☐ Platelet count LESS THAN or EQUAL to 100,000 AND Central Nervous System Surgery
☐ Active bleeding with recent Anti-platelet medications

Special Needs ☐ Irradiated ☐ CMV Negative ☐ Autologous

Date and Physician Signature

DATE: _____
09072507

TIME: _____

PHYSICIAN'S SIGNATURE



Blood Product Transfusion, continued

Orders, Continued

FRESH FROZEN PLASMA-250 ML _____ **UNIT(s) (P9017)** Rate: _____

Reason for Transfusion: _____

- ☐ Abnormal Coagulation studies and significant hemorrhage
- ☐ Prophylactic Use for INR GREATER THAN 1.5
- ☐ Reversal of Coumadin

Special Needs ☐ Irradiated ☐ CMV Negative ☐ Autologous

Nursing Orders

Initiate IV Vascular Access Flush Orders #0643 for: ☐ Peripheral Line ☐ Midline ☐ PICC ☐ Port

- ☒ Verify consent obtained for Transfusion of Blood and Blood Products.
- ☒ Obtain IV access.
- ☒ Vital Signs prior to transfusion for baseline. After transfusion started, vitals EVERY 15 MINUTES x 4, then EVERY HOUR until transfusion complete. Check vitals 1 hour after transfusion complete.

Post Transfusion

- ☐ HEMOGLOBIN AND HEMATOCRIT (85018 AND 85014) _____ hours post transfusion.
- ☐ PLATELET COUNT (85049) _____ hours post transfusion.

Transfusion Reaction

- ☒ If Transfusion reaction occurs, initiate Transfusion Reaction orders #0997.

Discharge

- ☒ Discharge home 30 minutes after transfusion complete if stable.

Date and Physician Signature

DATE: _____
09072507

TIME: _____

PHYSICIAN'S SIGNATURE