NORMAN REGIONAL Health System

Outpatient Infusion Center

Fax: 405-515-5089
Phone: 405-515-2470

ORD

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):**
☑ 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/Hemotocrit_____ 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:_____ **TIME:_____**

_____
PHYSICIAN'S SIGNATURE

DO NOT WRITE ON OR BELOW THIS AREA ORDERS MAY BE CUT OFF BY FAX MACHINES

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:_____ **TIME:**_____

_____
PHYSICIAN'S SIGNATURE