Premier Health

PLACE LABEL HERE

Name: _____

Unit #: _____

Account #: _____

Outpatient Blood and Blood Components Transfusion Orders Page 1 of 2

Check All Boxes That Apply and Mark Out, Date and Initial Any Auto Checked Boxes That Do Not Apply:

Patient Name: _____ **DOB:** _____

Diagnosis: _____

Insurance: _____

*Please attach a copy of the patient's insurance information to this order.

Attestation by provider:

ATTESTATION STATEMENT

I have explained the potential risks, benefits, and side effects of the transfusion of blood or blood components, including the risk of death (if appropriate) to the patient and/or surrogate. This explanation included discussion of the likelihood of the patient achieving his or her goals and any potential problems that might occur during recuperation. Reasonable alternatives to the transfusion of blood or blood components including risks, benefits, and side effects were also discussed, as were the risks related to not receiving the transfusion of blood or blood components. The patient and/or surrogate have elected to proceed with the transfusion of blood or blood components.

_____ _____ _____

Signature of Physician ***Date*** ***Time***

Red Blood Cell Transfusion Orders:

Hemoglobin: _____ Date obtained: _____ (please send copy of labs with order)

☐ Type and Screen for: _____units Packed Red Blood Cells. Special Request: ☐Irradiated ☐Washed

**All products supplied to Premier Health facilities from Community Blood Center are prestorage leukoreduced. Leukoreduced products are considered CMV Safe and a recommended product to prevent transfusion transmitted CMV.*

☐ Prepare and Transfuse: _____units of Packed Red Blood Cells.

Red Blood Cell Transfusion Rate:

☐ Infuse at rate of 60mL/hr for the first 15 minutes and then at rate of 240mL/hr until completed.

☐ Patient is at risk of overload: infuse at rate of 60ml/hr for the first 15 minutes and then at a rate of 100mL/hr until completed.

Platelet Transfusion Orders:

Platelet Count: _____ Date obtained: _____ (please send copy of labs with order)

☐ Prepare and Transfuse: _____units of Platelets. Special Request: ☐Irradiated

**All products supplied to Premier Health facilities from Community Blood Center are prestorage leukoreduced. Leukoreduced products are considered CMV Safe and a recommended product to prevent transfusion transmitted CMV.*

Platelet Transfusion Rate:

☐ Infuse at rate of 120mL/hr for the first 5 minutes and then at rate of 300mL/hr until completed.

☐ Patient is at risk of overload: infuse at rate of 120ml/hr for the first 15 minutes and then at a rate of 100mL/hr until completed.

Premier Health

PLACE LABEL HERE

Name: _____

MRN: _____

Account #: _____

Outpatient Blood and Blood Components Transfusion Orders Page 2 of 2

Check All Boxes That Apply and Mark Out, Date and Initial Any Auto Checked Boxes That Do Not Apply:

Fresh Frozen Plasma Transfusion Orders:

INR: _____ Date obtained: _____ (please send copy of labs with order)

☐ Prepare and Transfuse: _____units of Fresh Frozen Plasma.

Fresh Frozen Plasma Transfusion Rate:

☐ Infuse at rate of 120mL/hr for the first 5 minutes and then at rate of 300mL/hr until completed.

☐ Patient is at risk of overload: infuse at rate of 120ml/hr for the first 15 minutes and then at a rate of 100mL/hr until completed.

Cryoprecipitate Transfusion Orders:

INR: _____ Date obtained: _____ (please send copy of labs with order)

☐ Prepare and Transfuse: _____units of Cryoprecipitate.

Cryoprecipitate Transfusion Rate:

☐ Infuse at rate of 300mL/hr for the first 15 minutes and then as rapidly as tolerated until completed.

Nursing Orders:

☑ Verify informed consent before administering blood products.

☑ Vital Signs at start of transfusion, 15 minutes into transfusion, then 30 minutes thereafter, and at the completion of the transfusion. Assess more frequently as needed per patient condition.

☑ Notify Physician of any signs of reaction.

Intravenous Therapy:

☑ CARRIER FLUID: 0.9% NaCl at 20ml/hr PRN (use if blood product not infusing)

☑ Heparin Flush (100 units/ml) 5mL PRN for central line

Medication Orders:

☐ acetaminophen (TYLENOL) 650 mg PO x 1 dose prior to transfusion

☐ diphenhydramine (BENADRYL) 25 mg PO x 1 dose prior to transfusion

☐ diphenhydramine (BENADRYL) 25 mg IV x 1 dose prior to transfusion

☐ furosemide (LASIX) 20mg IVP x 1 after first unit

☐ furosemide (LASIX) 40mg IVP x 1 after first unit

☐ furosemide (LASIX) 20mg IVP x 1 after second unit

☐ Other: _____

Additional Orders: _____

PHYSICIAN SIGNATURE: _____ **ID #:** _____ **DATE/TIME:** _____

PRINTED PHYSICIAN NAME: _____

Orders complete by RN: _____ DATE/TIME: _____