ORANGE REGIONAL
MEDICAL CENTER

Attachment B
Outpatient Blood Administration Order Form

Patient's Name _Stroogreen Kenneth_   Patient's DOB _7/3/35_
                last   first   MI
Today's date _11/4/19_ Diagnosis _D50.9_ Date requested for transfusion _11/4/19_
                                                          or _11/5/19_

☐ Emergent/life threatening (same day)   ☐ Non-emergent (next day)

Instructions to RN: Perform vital signs as per protocol. Hold transfusion and notify physician if patient complains of chills, flank pain, shortness of breath, chest pain, restlessness, infusion site pain or sudden changes in vital signs; order Transfusion Reaction Investigation. Informed transfusion consent has been obtained and the patient or health care proxy has been informed of the benefits, risks, and alternatives and has had opportunity to have questions answered. Valid signed consent is valid for 1 year (Fax # 845-333-1902).

Orders for Pretransfusion Tests:
☑ Type and Screen (required for all, valid for 3 days)
☑ CBC (required for red cell and platelet transfusions)
☐ INR/APTT (required for plasma transfusions)
☐ Fibrinogen (required for cryoprecipitate transfusions)

Indications for Special Requirements:
Irradiated: Neonate, Leukemia, Lymphoma, directed donors
CMV Neg: Neonate, CMV Neg transplant candidate/recipient
HgbS Neg: Sickle Cell patients

Rate of Infusion: ☑ 2 Hours for clinically indicated hemodynamically stable patients ☐ 4 Hours
For more information on the rate of infusion refer to policy on Blood Transfusion Administration

Orders for Blood Products:
☑ **1 unit leukocyte reduced packed red cells**   ☐ Irrad ☐ CMV Neg ☐ HgbS Neg
☐ Hemoglobin less than 5 g/dL for sickle cell with congestive heart failure, hypotension, dyspnea.
☐ Hemoglobin less than 7 g/dL with symptomatic chronic anemia, with hematology evaluation or consult.
☐ Hemoglobin less than 7 g/dL with autoimmune hemolysis and cardiopulmonary syndrome.
☐ Hemoglobin less than 8 g/dL with acute cardiopulmonary syndrome
☐ Hemoglobin less than 9 g/dL prior to surgical procedure.
☑ Hemoglobin less than 9 g/dL with cancer, myelodysplastic disorder on chemotherapy.
☐ Hemoglobin less than 10 g/dL with thalassemia to suppress bone marrow.

☐ **2 units leukocyte reduced packed red cells**   ☐ Irrad ☐ CMV Neg ☐ HgbS Neg
☐ Hemoglobin less than 6 g/dL with cancer, myelodysplastic disorder on chemotherapy, or pre-op.
☐ Hemoglobin less than 9 g/dL with thalassemia to suppress bone marrow.

☐ **1 unit leukocyte reduced apheresis platelets**   ☐ Irrad ☐ CMV Neg
☐ Prophylactic correction of platelet count of less than 10,000 if at risk of hemorrhage.
☐ Active hemorrhage or pre-op for platelet count of less than 50,000.
☐ Correction due to anti-platelet agent for active hemorrhage or pre-operative.

☐ **1 unit plasma**
☐ INR greater than 2.0 prior to an invasive procedure, 1 unit at a time until corrected.
☐ INR greater than 1.5 for active hemorrhage, 1 unit at a time until corrected.
☐ Documented coagulation factor deficiency, 1 unit at a time only if clotting factor not available.
☐ Hereditary angioedema treatment, 1 unit at a time until symptoms relieved.

☐ **1 dose cryoprecipitate**
☐ Fibrinogen less than 100 mg/dL.
☐ Fibrinogen less than 150 mg/dL with active hemorrhage.
☐ Uremic bleeding when alternatives cannot control hemorrhage.

Orders for Pre-Transfusion Medication:
☐ Furosemide (Lasix) 20 mg IV, once   ☐ Diphenhydramine (Benadryl) 25 mg capsule, oral, once
☑ Diphenhydramine (Benadryl) 25 mg IV, once   ☑ Acetaminophen (Tylenol) 650 mg tablet, oral, once
☐ Hydrocortisone (Solu-Cortef) 100 mg IVPB, once

Ordering Physician's Name (print) _Dr. Gurinder Sethi_ Physician's phone _845-703-6999_
Ordering Physician's Signature _____ Date _11/4/19_

Fax completed order to ORMC Infusion Center (845-333-1902) and ORMC Blood Bank (845-333-0137)   Rev 04/23/19

☑ FAXED ☐ EMAILED

BY _____ DATE _11/4/19_