Vancouver CoastalHealth
VA: VGH / UBCH / GFS
VC: BP / Purdy / GPC

ADDRESSOGRAPH

**COMPLETE OR REVIEW ALLERGY STATUS PRIOR TO WRITING ORDERS**

# INFUSION OF HEMATOPOIETIC PROGENITOR CELLS (MARROW, APHERESIS OR CORD) OR THERAPEUTIC CELLS (T-CELLS)

(items with check boxes must be selected to be ordered)



Time Processed
RN/LPN Initials
Comments

Date: _____ Time: _____

The following product to be administered on (date) _____ at (time) _____.

☐ Hematopoietic progenitor cells, marrow
☐ Hematopoietic progenitor cells, marrow – Cryopreserved

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☐ Hematopoietic progenitor cells, apheresis
☐ Hematopoietic progenitor cells, apheresis – Cryopreserved

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☐ Hematopoietic progenitor cells, cord - Cyropreserved

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☐ Therapeutic cells, T-cells
☐ Therapeutic cells, T-cells – Cryopreserved

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Above product to be administered in accordance with the Leukemia/BMT guidelines for the *Infusion of Cellular Products* (refer to Leukemia/BMT Standard Operating Procedures).

White cell filter tubing is absolutely contraindicated. Infuse through a Y-type blood product administration set (170 to 260 micron) Y-connected to a non-filtered IV tubing with distal access port (all primed with sodium chloride 0.9% (NS)). Do NOT infuse through an IV infusion pump.

Hold all IV infusions, blood products and medications except for cycloSPORINE during infusion.

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_____ Prescriber's Signature

_____ Printed Name

_____ College ID

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(items with check boxes must be selected to be ordered)



Time Processed
RN/LPN Initials
Comments

Date: _____ Time: _____

☐ CRYOPRESERVED HEMATOPOIETIC PROGENITOR CELLS (MARROW, APHERESIS OR CORD) OR THERAPEUTIC CELLS (T-CELLS)

MONITORING:

Baseline vital signs prior to infusion, then Q15MIN during infusion and for 1 hour post-infusion.

Continuous pulse oximetry until 15 minutes post-infusion then Q15MIN until 1 hour post-infusion.

Notify physician immediately if temperature equal to or greater than 38° C during or after infusion.

PREMEDICATIONS:

☐ hydrocortisone 100 mg IV 1 hour pre-infusion

diphenhydrAMINE 50 mg IV 30 MIN pre-infusion

acetaminophen 650 mg PO 30 MIN pre-infusion

☐ ondansetron 8 mg PO 30 MIN pre-infusion

☐ other : _____

☐ NON-CRYOPRESERVED HEMATOPOIETIC PROGENITOR CELLS (MARROW, APHERESIS OR CORD) OR THERAPEUTIC CELLS (T-CELLS)

MONITORING:

Baseline vital signs prior to infusion, then Q15MIN x 4 and Q1H for duration of infusion.

Notify physician immediately if temperature equal to or greater than 38° C during or after infusion.

PREMEDICATIONS (Consider in patients with history of reaction to blood products or ABO incompatibility):

☐ diphenhydrAMINE 50 mg IV 30 MIN pre-infusion

☐ acetaminophen 650 mg PO 30 MIN pre-infusion

☐ other : _____

FAX ORDERS TO PHARMACY

FAX ORDERS TO CLINICAL CELL THERAPY (CCT) 604-675-8149

FAX INFUSION RECORD TO THE FOLLOWING:

Bone Marrow Transplant Program (604-875-5678)

Clinical Cell Therapy (604-675-8149)

Apheresis Unit (604-875-5053)

Transfusion Medicine Services (604-875-5284)

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