

## OUTPATIENT BLOOD PRODUCT TRANSFUSION ORDERS (ADULT)

**PLACE OF TRANSFUSION:**

- ATC
- Oncology
- Other: \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_

**DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

**DATE OF TRANSFUSION:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Type and Screen only

**SPECIAL INSTRUCTIONS**

**OPTIONS:**

- Irradiated
- CMV Negative

**INDICATION:**

- Immunosuppressed, specify \_\_\_\_\_
- Other, specify \_\_\_\_\_

**PACKED RED BLOOD CELLS**

**VOLUME TO BE INFUSED:**

**INDICATION:**

**Current Hemoglobin:** \_\_\_\_ g/dl    **Hematocrit:** \_\_\_\_

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> 1 unit</li> <li><input type="checkbox"/> ____ units</li> </ul> <p>Give each unit over ____ hrs.</p> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Hemoglobin less than or equal to 7 g/dl or Hematocrit less than or equal to 21%</li> <li><input type="checkbox"/> Hemoglobin less than 8 g/dl or Hematocrit less than 24% with CAD or risk of organ ischemia</li> <li><input type="checkbox"/> Hemoglobin less than 8 g/dl or Hematocrit less than 24% with chemotherapy</li> <li><input type="checkbox"/> Acute or ongoing blood loss</li> <li><input type="checkbox"/> Other, specify _____</li> </ul> |
|---|--|

**PLATELETS**

Apheresis Unit (30,000 – 50,000 increase)

**Current Platelet Count:** \_\_\_\_ K/ul

**VOLUME TO BE INFUSED:**

**INDICATION:**

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> 1 unit</li> <li><input type="checkbox"/> ____ units</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Platelet count less than 10,000 /ul</li> <li><input type="checkbox"/> Platelet count less than 20,000/ul with signs of hemorrhagic diathesis (petechiae, mucosal bleeding)</li> <li><input type="checkbox"/> Platelet count less than 50,000 /ul with: <ul style="list-style-type: none"> <li><input type="checkbox"/> active bleeding</li> <li><input type="checkbox"/> invasive procedure (recent, in-progress, planned)</li> </ul> </li> <li><input type="checkbox"/> Platelet count less than 100,000 /ul with cardiopulmonary bypass or neurosurgical procedure</li> <li><input type="checkbox"/> Platelet dysfunction, specify _____</li> <li><input type="checkbox"/> Other, specify _____</li> </ul> |
|--|--|

**PLASMA**

**Current INR:** \_\_\_\_    **PTT:** \_\_\_\_    **Fibrinogen:** \_\_\_\_

**VOLUME TO BE INFUSED:**

**INDICATION:**

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> ____ units</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Clinical coagulopathy and significant hemorrhage</li> <li><input type="checkbox"/> INR greater than 1.5 with active bleeding or planned invasive procedure</li> <li><input type="checkbox"/> Emergent reversal of some anticoagulants</li> <li><input type="checkbox"/> Other, specify _____</li> </ul> |
|---|---|

**Medication(s) Ordered:**

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Tylenol 650mg by mouth x 1 dose</li> <li><input type="checkbox"/> Benadryl 25mg by mouth x 1 dose</li> <li><input type="checkbox"/> Other _____</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Lasix ____ mg IV to be given: <ul style="list-style-type: none"> <li><input type="checkbox"/> Before transfusion</li> <li><input type="checkbox"/> In between units</li> </ul> </li> </ul> |
|--|--|

**Diagnosis:**

- Anemia (285.9) (D649)     Thrombocytopenia, primary (287.30) (D6949)     Thrombocytopenia, secondary (287.49) (D6959)
- Sickle-cell disease (282.60) (D571)     Thrombotic thrombocytopenia purpura (287.31) (D693)
- Other: \_\_\_\_\_

All items ordered above are medically necessary.

Physician's Signature \_\_\_\_\_

Time: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Label