Infusion

Blood Products Transfusion Order

Salem Health® Hospitals & Clinics

PATIENT INFORMATION

Last Name: ______________ **First Name:** ______________ **MI:** ____ **DOB:** ________
Address: ______________ Phone: ________
City: ______________ State: ________ Zip Code: ________
Emergency Contact: ______________ Relationship: ________ Phone: ________

PROVIDER INFORMATION

Referring Provider: ______________ Phone Number: ________ Fax Number: ________

ADDITIONAL INFORMATION

☐ Check if Patient is uninsured.Provide ICD-10 code **AND** description: ______________
Weight: ______ **Allergies:** ______________
Is the patient ambulatory? ☐ Yes ☐ No Does the patient require bariatric equipment? ☐ Yes ☐ No

ORDERS PRECEDED BY A ☐ REQUIRE A ☒ TO INITIATE THE ORDER.)

Red blood Cell transfusion:
☐ Type & Cross and hold **OR** ☐ Type & Cross and Transfuse ________ Units of PRBC *(SH uses leukoreduced CMV safe RBCs)*
Irradiate Unit? Yes NO (order will be returned if not selected)

Type & Cross and Transfuse:
(select only one time interval) ☐ STAT *(Within 24 hrs)* **OR** ☐ Within 25-48 hrs. **OR** ☐ Within 49-72 hrs.
☐ Reference Lab: Red Blood Cell Antibody Identification

Platelets:
☐ Transfuse ________ Units Irradiate Unit? Yes No (order will be returned if not selected) ☐ HLA Cross match
(HLA testing is performed through American Red Cross and takes approx. 3 working days)
(select only one time interval) ☐ **STAT** *(Within 24 hrs.)* **OR** ☐ within 25-48 hrs. **OR** ☐ within 49-72 hrs.

Pre-Medications: **Select One** ☐NO Pre-Medications **OR** Administer pre-meds **30 min prior to transfusion**

☐ Acetaminophen P.O. Every 4 hrs. (*select **one** dose*) ☐500 mg **OR** ☐650 mg **OR** ______mg
☐ Diphenhydramine *(select **one dose**)* ☐12.5mg IV **OR** ☐25mg IV **OR** ☐50mg IV
☐ Dexamethasone *(select **one dose**)* ☐4mg IV **OR** ☐8mg IV **OR** ☐ 10mg IV
☐ Furosemide IV *(select **dose and frequency**)* ☐_____mg IV (select one) ____after each unit **OR** _____only Once
Other Instructions:

____

____

HCT______________ **Hgb** **Plt** **date of results**____________

PATIENTS WITH CENTRAL LINE ACCESS

☒ Central line care per Salem Health CVAD Access Policy. (Lippincott) or routine implanted port care per manufacture device maintenance card if card is available.

☒ Alteplase per Salem Health Central Venous Access Device declotting *(Lippincott)* for S/sx of occlusion: Inability to infuse fluids, no blood return, increased resistance when flushing, increased occlusion/high-pressure alarm when using an infusion pump, sluggish gravity flow.

☒ View Chest X-ray to verify catheter tip location PRN for: Catheter migration greater than 5 cm *(PICC only)*, signs and symptoms of tip malposition *(occlusion unresolved by Cathflo, discomfort in the arm, neck or chest, unusual sensations or sounds when flushing, neck vein engorgement, or heart palpitations.)* Notify Physician or Provider

X Blood bank may substitute irradiated blood or platelets for non-irradiated or psoralen treated platelets for irradiated or non-irradiated based on availability per blood bank policy

X Follow SH OP Infusion reaction algorithm for symptoms of an infusion reaction. Notifiy provider if implemented. Follow steps defined in the SH blood administration for adults policy (section C 1-3)

______________ ______________ ________
Provider Signature Provider Printed Name Date: