



Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO9031



ADULT AMBULATORY INFUSION ORDER
Blood Transfusion Orders

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ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____ kg Height: _____ cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ Patient to follow up with provider on date: _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note.**
2. For Adventist patients: PARQ: Required _____ (initials): "I have discussed the risks versus benefits of blood products designated below, as well as the risks and alternatives, with the patient/surrogate; they understand and agree to transfusion therapy"
3. The Transfusion Blood Consent form must be completed annually.
4. To order blood transfusion products both an INFUSION PLAN and an ORDER PANEL must be ordered:
 - a. INFUSION PLAN: "Blood Transfusion": includes pre-medications and treatment parameters
 - b. ORDER PANEL: "CHO Blood Transfusion Orders": blood products and orders to transfuse
5. All patients automatically receive pre-storage leukodepleted, CMV safe red cell and platelet products. If irradiated is needed, please order under special needs section below.

LABS:

- CBC with differential, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One
- Platelet count, whole blood, Routine, AS NEEDED, 1 hour post-platelet count if on Platelet Refractory Protocol
- Platelet count, whole blood, Routine, ONCE
- Type & Screen, Routine, ONCE
- Labs already drawn. Date: _____

NURSING ORDERS:

1. VITAL SIGNS – Routine vital signs
2. Review previous hemoglobin & hematocrit. If results not acceptable to blood bank due to internal dating policies, order CBC.
3. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes

PRE-MEDICATIONS: (Administer 30 minutes prior to infusion)

Note to provider: Please select which medications below, if any, you would like the patient to receive prior to treatment by checking the appropriate box(s)

- acetaminophen (TYLENOL) tablet, 650 mg, oral, ONCE, every visit
- diphenhydrAMINE (BENADRYL) capsule, 50 mg, oral, ONCE, every visit.
Give either loratadine or diphenhydrAMINE, not both.
- loratadine (CLARITIN) 10 mg tablet, oral, ONCE AS NEEDED if diphenhydrAMINE is not given, every visit. Give either loratadine or diphenhydrAMINE, not both.
Give either loratadine or diphenhydrAMINE, not both.



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BLOOD PRODUCT(S): (Ordered using ORDER PANEL):

• **Packed Red Blood Cells (See below for special needs)**

- Amount
 - _____ units
 - _____ mL
- Duration
 - Per OHSU Transfusion Policy (RBCs: 100 mL/hour for 15 minutes then increase to max rate 250 mL/hour for remainder of the unit if tolerated).
 - _____ hours/unit
 - _____ mL/hour
- Transfusion Parameters:
 - Hgb \leq 7 g/dL
 - Hgb \leq 8 g/dL and cardiovascular disease
 - Clinically significant acute blood loss
 - For upcoming surgery
 - Other: _____
- Interval
 - ONCE (appointment date: _____)
 - Every _____ days for _____ treatments. Begin on date: _____
- Patient consented for transfusion, and documentation in med record?
 - Yes (fax consent to applicable infusion clinic)
 - No

• **Pheresis Platelets (See below for special needs)**

- Matched
 - HLA Matched
 - Crossmatched
- Amount
 - _____ units
 - _____ mL
- Duration
 - _____ hours/unit
 - _____ mL/hour
- Transfusion Parameters:
 - Platelet count $<$ 10,000 + failure of platelet production
 - Platelet count $<$ 20,000 + signs of hemorrhagic diathesis (petechiae, mucosal bleeding)
 - Platelet count $<$ 50,000 + clinical indications
 - Other: _____
- Interval
 - ONCE (appointment date: _____)
 - Every _____ days for _____ treatments. Begin on date: _____
- Patient consented for transfusion, and documentation in med record?
 - Yes (fax consent to applicable infusion clinic)
 - No



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• **Frozen Plasma (See below for special needs)**

- Amount
 - _____ units
 - _____ mL
- Duration _____ hours
- Interval
 - ONCE (appointment date: _____)
 - Every _____ days for _____ treatments. Begin on date: _____
- Patient consented for transfusion, and documentation in med record?
 - Yes (fax consent to applicable infusion clinic)
 - No

• **Cryoprecipitate Pool (See below for special needs)**

- Amount _____ pools (NOTE: 1 pool = 5 units. Usual adult dose = 2 pools)
- Duration _____ hours
- Interval
 - ONCE (appointment date: _____)
 - Every _____ days for _____ treatments. Begin on date: _____
- Patient consented for transfusion, and documentation in med record?
 - Yes (fax consent to applicable infusion clinic)
 - No

• **Special Needs**

- CMV REDUCED RISK (may use Leukoreduced or CMV seronegative)
- CMV SERONEGATIVE
- DIRECTED DONOR
- IRRADIATED
- LEUKOREDUCED
- WASHED
- PHENOTYPE MATCHED (rarely indicated)
- OTHER _____

ROUTINE MEDICATIONS:

- furosemide (LASIX) _____ mg IV, ONCE (after the first unit of blood product)



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HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.5 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
6. sodium chloride 0.9% bolus, 1000 mL, intravenous, Administer over 60 minutes, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

By signing below, I represent the following:

I am responsible for the care of the patient (*who is identified at the top of this form*);

I hold an active, unrestricted license to practice medicine in: Oregon _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____

Please indicate the patient's preferred clinic location below

<input type="checkbox"/> HILLSBORO MEDICAL CENTER 364 SE 8th Ave, Medical Plaza Suite 108B, Hillsboro, OR 97123	Phone (503) 681-4124 Fax (503) 681-4120
<input type="checkbox"/> ADVENTIST HEALTH – PORTLAND Infusion Services, 10123 SE Market St, Portland, OR 97216	Phone (503) 261-6631 Fax (503) 261-6756
<input type="checkbox"/> ADVENTIST HEALTH – COLUMBIA GORGE Celilo Cancer Center, 1800 E 19th St, The Dalles, OR 97058	Phone (541) 296-7585 Fax (541) 296-7610