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)*
☐ Irradiated

Type & Cross and Transfuse:

*(select only **one** time interval)* ☐ STAT *(Within 24 hrs)* **OR** ☐ Within 25-48 hrs. **OR** ☐ Within 49-72 hrs.

Platelets:

☐ Transfuse _____ Units ☐ Irradiated ☐ 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:

☐ NO Pre-Medications **OR** ☐ 30 min prior to transfusion **OR** ☐ Follow SH Infusion reaction protocol for symptoms of infusion reaction

☐ Acetaminophen P.O. Every 4 hrs. (*select **one***) ☐ 500 mg **OR** ☐ 650 mg **OR** _____ mg
☐ Diphenhydramine *(select **one dose, circle route**)* ☐ 12.5mg IV PO **OR** ☐ 25mg IV PO **OR** ☐ 50mg IV PO
☐ Dexamethasone *(select **one**)* ☐ 4mg IV **OR** ☐ 8mg IV **OR** ☐ 10mg IV
☐ Furosemide IV *(select **one**)* ☐ _____ mg IV *(select **one**)* _____ after each unit **OR** _____ only Once

Other Instructions: _____
Patient has a ☐ PICC OR or other CVAD ☐ Implanted port ☐ Pt does not have a CVAD

Lab results:

HCT: _____ HGB: _____ PLT: _____ Date Obtained: _____

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

☒ Blood bank may substitute irradiated product for non-irradiated based on availability per SH Blood Bank policy BB047 Blood product irradiation.

_____ _____ _____
Provider Signature Provider Printed Name Date: