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

PO9031

ADULT AMBULATORY INFUSION ORDER

Blood Transfusion Orders

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: _____

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NURSING ORDERS:

1. VITAL SIGNS – Routine vital signs
2. TREATMENT PARAMETERS – ***(Attention Providers, please assign appropriate parameters)***
    a. Blood Transfusion:
        i. For Hemoglobin less than or equal to _____ g/dL, transfuse _____ units of packed red blood cells per OHSU transfusion policy (RBCs: 100 mL/hour x 15 minutes then increase to max rate 240 mL/hour for remainder of the unit if tolerated).
        OR
        ii. For Hematocrit less than or equal to _____ %, transfuse _____ units of packed red blood cells per OHSU transfusion policy (RBCs: 100 mL/hour x 15 minutes then increase to max rate 240 mL/hour for remainder of the unit if tolerated).
    b. Platelet Transfusion: For Platelet count less than or equal to _____, transfuse ___ units pheresis platelet product.
3. Review previous hemoglobin & hematocrit. If results not acceptable to blood bank due to internal dating policies, order CBC.
4. 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.

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

- **Packed Red Blood Cells (See below for special needs)**
    - Amount
        - ☐ _____ units
        - ☐ _____ mL
    - Duration
        - ☐ _____ hours/unit
        - ☐ _____ mL/hour
    - 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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- **Pheresis Platelets (See below for special needs)**
  - Matched
    - ☐ HLA Matched
    - ☐ Crossmatched
  - 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
-
- **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 _____

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ROUTINE MEDICATIONS:

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

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, 0.3 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**: _____

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Please check the appropriate box for the patient's preferred clinic location:

☐ **Hillsboro Medical Center**
Infusion Services
364 SE 8th Ave, Medical Plaza Suite 108B
Hillsboro, OR 97123
Phone number: (503) 681-4124
Fax number: (503) 681-4120

☐ **Mid-Columbia Medical Center**
Celilo Cancer Center
1800 E 19th St
The Dalles, OR 97058
Phone number: (541) 296-7585
Fax number: (541) 296-7610

☐ **Adventist Health Portland**
Infusion Services
10123 SE Market St
Portland, OR 97216
Phone number: (503) 261-6631
Fax number: (503) 261-6756