

ALLERGY NO YES WT. _____ (kg) HT. _____
IF YES, PLEASE STATE _____

PEDIATRIC/BLOOD PRODUCT INFUSION PROTOCOL ORDER (Blood product review will be performed unless exclusion criteria met as per list on reverse side)	
1.	Transfusion consent signed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Completed Previously
2.	Reason for Transfusion (See reverse side for indications) <input type="checkbox"/> Actively bleeding <input type="checkbox"/> Thrombocytopenia <input type="checkbox"/> Iatrogenic blood loss (>10% EBV) <input type="checkbox"/> Known factor deficiency (VII, XII, vWF) <input type="checkbox"/> Chronic anemia <input type="checkbox"/> Fibrinogen <150 <input type="checkbox"/> Hypotension <input type="checkbox"/> PT (INR) PTT >1.5 x normal <input type="checkbox"/> Increase O ₂ carrying capacity Describe reason(s) not otherwise listed: _____
3.	Transfuse the following blood product(s): Note: prestorage leukoreduced blood products are considered "CMV safe"; CMV negative products are individually tested for CMV by the donor center and may require special shipments which can result in delayed availability) <div style="display: flex; flex-direction: column;"> <div style="margin-bottom: 10px;"> RBC Leukoreduced packed cells, transfuse _____ mL Irradiated, leukoreduced packed cells, transfuse _____ mL **CMV negative leukoreduced packed cells, transfuse _____ mL **Irradiated CMV negative leukoreduced packed cells, transfuse _____ mL *Directed donation leukoreduced packed cells, transfuse _____ mL </div> <div style="margin-bottom: 10px;"> PLATELET **Leukoreduced platelets, transfuse _____ mL **Irradiated, leukoreduced platelets, transfuse _____ mL </div> <div> PLASMA Frozen plasma, transfuse _____ mL Cryoprecipitate, transfuse _____ mL (average 10-15 mL/unit) **Granulocytes, transfuse _____ mL </div> </div> Immunoglobulin _____ (name of product) _____ gm per IV protocol or over _____ hrs **Other product not listed: _____ (name of product) _____ amount over _____ hrs. Rate of infusion or other special instructions: _____ (blood product units or aliquots must not exceed 4 hours infusion time) * Available if directed donation product has been received ** Product not routinely available and may result in transfusion delay necessitated by product shipment
4.	Labs: Pre-transfusion <input type="checkbox"/> Hgb <input type="checkbox"/> Plt count <input type="checkbox"/> CBC (includes hgb and plt count) Post-transfusion <input type="checkbox"/> Hgb <input type="checkbox"/> Plt count <input type="checkbox"/> CBC (includes hgb and plt count) <input type="checkbox"/> PT (includes INR) <input type="checkbox"/> PTT Other tests not listed: _____ Time of testing: _____
5.	Give pre-medications before transfusion <input type="checkbox"/> Acetaminophen (Tylenol) 10-15 mg/kg Dose = _____ mg (po). <input type="checkbox"/> IV Methylprednisolone _____ mg <input type="checkbox"/> IV Dexamethasone (Decadron) _____ mg <input type="checkbox"/> IV Diphenhydramine (Benadryl) 1 mg/kg Dose = _____ mg <input type="checkbox"/> IV Furosemide (Lasix) _____ mg before, _____ mg during, _____ mg post transfusion <input type="checkbox"/> Other _____ <input type="checkbox"/> NA Repeat above medications except furosemide after _____ hrs as (<input type="checkbox"/> Scheduled dose <input type="checkbox"/> prn)
6.	IV access: <input type="checkbox"/> Catheter <input type="checkbox"/> Port <input type="checkbox"/> Start Peripheral <input type="checkbox"/> UAC/UVC
7.	I have discussed with the patient/family the nature and purpose of the proposed treatment, risks and consequences, reasonable and feasible treatment alternatives, and the prognosis if no treatment is given and have given the patient/family the opportunity to ask any questions they may have.
Orders with a checkbox present must be checked off to be implemented. Orders without a checkbox present will be implemented unless stricken out. Signature: _____ Date: _____ Time: _____	

ORDER SHEET Scanned (Name) _____ (Date) _____ (Time) _____

Exclusions from Blood Review

Physician: Please note *If transfusion given outside of parameter, please justify use in medical record.

Red Cell Transfusion

- Hgb < 8 without active bleeding
- Hgb < 10 with evidence of active bleeding
- Symptomatic anemia

Platelets

- Need pre & post levels
- < 50,000 surgery cases or actively bleeding
- < 20,000 med cases
- < 100,000 in CABG, neurological or ophthalmological cases

Fresh Frozen Plasma

- Coags need pre & post (PT PTT, INR \geq 1.5 and/or PTT with results \geq 1.5 times normal).
- Post-transfusion coags should show correction to INR \leq 3.5
- Warfarin reversal in bleeding patient or patient needing surgery before pharmaceutical correction could occur, TTP and HUS patients, patients with deficient in ATIII, Protein C, Protein S or heparin cofactor II.

Cryo

- Fibrin glue, or Fibrinogen <100 mg.
- Known Factor VIII, XIII or VWF deficiency.

CONSENT FOR ADMINISTRATION OF BLOOD OR BLOOD PRODUCTS FOR NON-OPERATIVE CONDITIONS

I consent to the administration of blood or blood products during this current hospital admission or during the course of my long term treatment and have been informed of the risks, benefits and alternatives to transfusion (including no treatment) to treat

Type of blood or blood product administered: _____

(Refer to bottom of sheet for risks related to receiving blood transfusion.)

Patient Signature: _____

Date and Time: _____

Witness: _____

CONSENT FOR MINOR PATIENT OR PATIENT UNABLE TO GIVE CONSENT

The patient _____ is unable to give consent for the following reason(s) _____

As sponsor or guardian of the above named individual, I consent to the administration of blood or blood products during the current hospital admission and have been informed of the risks, benefits and alternatives (including no treatment).

Sponsor or Guardian Signature: _____

Date and Time: _____

Witness: _____

See Adult Blood/Blood Product Infusion Protocol Order for physician signature and compliance.

COMPLICATIONS OF BLOOD TRANSFUSION – USA

INFECTIOUS DISEASE

	<u>RISK PER UNIT</u>
Hepatitis C Virus	< 1 in 2,000,000
Hepatitis B Virus	1 in 200,000
Human T-Lymphotropic Virus	1 in 1,000,000
Human Immunodeficiency Virus (AIDS)	1 in 2,000,000
Bacteria	1 in 2,000
Other Infection	<1 in million

(West Nile Virus, Syphilis, Malaria, Chagas, Babesia)

REFERECNES:
AABB 2002
Dodd, Notari, Stramer
Transfusion 2002; 42:975

OTHER COMPLICATIONS

	<u>RISK PER UNIT</u>
Acute Hemolysis	1 in 15,600 to 35,700
Fatal Acute Hemolysis	1 in 630,000
Delayed Hemolysis	1 to 4,000 to 11,600
Fatal Delayed Hemolysis	1 in 3.85 million
Febrile, Non-hemolytic	1 in 50 to 100
Acute Lung Injury	1 in 5,000 to 100,000
Hives	1 in 30 to 100
Severe Anaphylaxis	1 in 18,000 to 170,000
Circulatory Overload	1 in 3,000 to 12,000
Transfusion-Associated Graft-VS-Host Disease	Unknown

Popovsky
AABB Press, 1996
Revised: June 2003