<table>
<thead>
<tr>
<th><strong>ALLERGY</strong> □ NO □ YES</th>
<th>WT. _________ (kg)</th>
<th>HT. _________</th>
</tr>
</thead>
</table>

**OUTPATIENT ADULT BLOOD / BLOOD PRODUCT INFUSION ORDER – EPIC 1387**

**BLOOD PRODUCT REVIEW WILL BE PERFORMED UNLESS EXCLUSION CRITERIA MET AS PER LIST ON REVERSE SIDE**

### 1. Schedule Transfusion for
- [ ] Today
- [ ] Tomorrow
- [ ] 2 days from now
- [ ] 3 days from now

**All Outpatient Blood Administration orders will expire in 3 days**

### 2. Transfusion consent signed
- [ ] Yes
- [ ] No
- [ ] Completed previously

### 3. Reason for Transfusion (See reverse side for indications)
- [ ] Acute Blood Loss Anemia (hgb less than 10)
- [ ] Thrombocytopenia
- [ ] Postoperative Anemia due to Perioperative Blood Loss
- [ ] Known factor deficiency (VII, XII, vWF)
- [ ] Chronic Anemia (hgb less than 8 or symptomatic anemia)
- [ ] Fibrinogen less than 150
- [ ] Hypotension
- [ ] PT (INR) PTT greater than 1.5 x normal
- [ ] To increase O₂ carrying capacity

**Describe other reasons not listed above**

### 4. Special Instructions:

**Crossmatch**
- [ ] (# units) of PRBC’s

**Transfuse the following blood product(s):**

- **RBC**
  - Leukoreduced Packed Cells, transfuse ______ unit(s)
  - Irradiated, leukoreduced packed cells, transfuse ______ unit(s)
  - "Autologous red cells, transfuse ______ unit(s)"
  - **CMV tested negative, leukoreduced packed cells, transfuse ______ unit(s)"
  - "Irradiated & CMV negative leukoreduced packed cells, transfuse ______ unit(s)"

- **PLATELETS**
  - Pheresed, leukoreduced platelets, transfuse ______ unit(s) (1 unit = 6-8 pooled random donor platelets)
  - Irradiated, leukoreduced pheresed platelets, transfuse ______ unit(s)
  - **CMV tested negative, leukoreduced pheresed platelets, transfuse ______ unit(s)"
  - **CMV tested negative & irradiated, leukoreduced pheresed platelets, transfuse ______ unit(s)"

- **PLASMA**
  - Frozen plasma, transfuse ______ unit(s)
  - Cryoprecipitate, transfuse ______ unit(s)
  - "Granulocytes, transfuse ______ unit(s)"
  - "Other product (e.g.: IVIG) ______ _______, transfuse ________ (amount)"

- [ ] Available if preoperative self-donated product has been received
- [ ] Product not routinely available and may result in transfusion delay necessitated by product shipment

**Rate of infusion**

(individual units or containers must not exceed 4 hours infusion time)

### 5. Post transfusion lab (order if appropriate)
- [ ] Hgb
- [ ] Plt
- [ ] CBC (includes hgb & plt)
- [ ] PT (includes INR)
- [ ] PTT
- [ ] Other ________

**Time ________**

### 6. Medications:

- [ ] NS 250 mL 15-100 mL/hr IV as directed PRBC and platelet transfusion
- [ ] Acetaminophen (Tylenol) 650mg (po) before transfusion x 1 dose. May repeat after ________ hrs prn x 1 dose.
- [ ] Methylprednisolone Sodium Succinate ______ mg IV before transfusion x 1 dose. May repeat after ________ hrs prn x 1 dose.
- [ ] Dexamethasone (Decadron) ______ mg IV before transfusion x 1 dose. May repeat after ________ hrs prn x 1 dose.
- [ ] Diphenhydramine (Benadryl) ______ mg IV before transfusion x 1 dose. May repeat after ________ hrs prn x 1 dose.
- [ ] Furosemide (Lasix) ______ mg IV before transfusion x 1 dose.
- [ ] Furosemide (Lasix) ______ mg IV during transfusion x 1 dose.
- [ ] Furosemide (Lasix) ______ mg IV post transfusion x 1 dose
- [ ] Other ________

**NA**

### 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 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.

**Physician Signature:** ____________________________

**Date:** ____________________________  **Time:** ____________________________

---

**ORDER SHEET**  Department of Pathology – Revised: 1/25/2011  05-002-1/2  5200601
CONSENT FOR BLOOD/COMPONENTS TRANSFUSIONS
(MEDICAL)

1. (Print patient’s name) ___________________________________________ agree to get blood components.

2. I have had a chance to talk with my doctor or health care team about:
   a. Why I need a transfusion (medical condition) _____________________________.
   b. What a blood transfusion is.
   c. How a transfusion might harm me.
   d. My choices for treatment. The risks of those choices.
   e. How I might feel after. How quickly I should recover.
   f. I understand the team will be double checking who I am. This is to protect me.

I have had my questions answered. I agree to the above plan.

Signature: ___________________________________________ Date ____________ Time ____________

Reason if patient unable to sign: ______________________________________________________

DOCTOR/PROVIDER:

I have answered the patient/family’s questions about the proposed plan.

Signature: ___________________________ Date ____________ Time ____________

(no other signature required if provider witnesses signature)

WITNESS:

I have verified that the signature is that of the patient’s or representative’s. This form has been signed before the procedure.

Signature: ___________________________________________ Date ____________ Time ____________

Signature: ___________________________________________ Language/Organization ____________ Time ____________

Interpreter Name (please print) ___________________________________________ Time ____________

Complications of Blood Transfusions – USA

<table>
<thead>
<tr>
<th>INFECTION DISEASE</th>
<th>RISK PER UNIT</th>
<th>OTHER COMPLICATIONS</th>
<th>RISK PER UNIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis C Virus</td>
<td>less than 1 in 2,000,000</td>
<td>Acute Hemolysis</td>
<td>1 in 15,600 to 35,700</td>
</tr>
<tr>
<td>Hepatitis B Virus</td>
<td>1 in 200,000</td>
<td>Fatal Acute Hemolysis</td>
<td>1 in 630,000</td>
</tr>
<tr>
<td>Human T-Lymphotropic Virus</td>
<td>1 in 3,000,000</td>
<td>Delayed Hemolysis</td>
<td>1 in 4,000 to 11,600</td>
</tr>
<tr>
<td>Human Immunodeficiency Virus</td>
<td>1 in 2,000,000</td>
<td>Fatal Delayed Hemolysis</td>
<td>1 in 3.8 million</td>
</tr>
<tr>
<td>Bacteria</td>
<td>less than 1 in million</td>
<td>Febrile, Non-Hemolytic</td>
<td>1 in 50 to 100</td>
</tr>
<tr>
<td>Other Infection (Syphilis, Malaria, Chagas, Babesia)</td>
<td>less than 1 in million</td>
<td>Acute Lung Injury</td>
<td>1 in 2,000 to 3,000*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hives</td>
<td>1 in 30 to 100</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Severe Anaphylaxis</td>
<td>1 in 18,000 to 170,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Circulatory Overload</td>
<td>1 in 3,000 to 12,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Transfusion-Associated</td>
<td>Unknown</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Graft-VS-Host Disease</td>
<td></td>
</tr>
</tbody>
</table>

REFERENCES: Dodd, Notari, Stramer

<table>
<thead>
<tr>
<th>TRANSMISSIBLE INFECTION</th>
<th>RISK PER UNIT</th>
<th>OTHER COMPLICATIONS</th>
</tr>
</thead>
</table>

Exclusions from Blood Review

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

Red Cell Transfusion
- Hgb less than 8 without active bleeding
- Hgb less than 10 with evidence of active bleeding
- Symptomatic anemia

Platelets
- Need pre & post levels
- less than 50,000 surgery cases or actively bleeding
- less than 20,000 med cases
- less than 100,000 in CAGB, neurological or ophthalmological cases

Fresh Frozen Plasma
- Coags need pre & post
  (PT PTT, INR greater than or equal to 1.5 and/or PTT with results greater than or equal to 1.5 times normal).
- Post-transfusion coags should show correction to INR less than or equal to 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 less than 100 mg.
- Known Factor VIII, XIII or VWF deficiency.