Physician’s Orders
BLOOD PRODUCTS - ADULT, OUTPATIENT, INFUSION CENTER
Page 1 to 3

 Defaults for orders not otherwise specified below:

☐ Interval: Once
☐ Interval: Every _____ Days (Oncologists/Hematologists only)
☐ Interval: Every Visit (Oncologists/Hematologists only) – Standing orders, requires scheduling instruction sheet for each subsequent transfusion need to get patient scheduled

Duration:
☐ Until date: __________
☐ 1 year
☐ _____ # of Treatments

Anticipated Infusion Date__________ ICD 10 Code with Description________________________________________

Height_____ (cm) Weight_______ (kg) Allergies________________________________________

Provider Specialty
☐ Allergy/Immunology ☐ Infectious Disease ☐ OB/GYN ☐ Rheumatology
☐ Cardiology ☐ Internal Med/Family Practice ☐ Other ☐ Surgery
☐ Gastroenterology ☐ Nephrology ☐ Otolaryngology ☐ Urology
☐ Genetics ☐ Neurology ☐ Pulmonary ☐ Wound Care
Site of Service
☐ SH Gerber ☐ SH Lemmen Holton (GR) ☐ SH Pennock ☐ SH United Memorial
☐ SH Helen Devos (GR) ☐ SH Ludington ☐ SH Reed City ☐ SH Zeeland

Blood Products

☐ Prepare & Transfuse RBC
☐ 1 Units
☐ 2 Units

Transfusion indications:
☐ Acute bleeding with hemodynamic instability
☐ Hgb < 7 g/dL And/OR Hct < 21% in a patient with no medical comorbidities
☐ Hgb < 8 g/dL And/OR Hct < 24% in a non-ICU patient undergoing orthopedic or cardiac
☐ Hgb < 10 g/dL And/OR Hct < 30% in a patient with acute coronary syndrome
☐ Other

Special Requirements:
☐ CMV Negative
☐ Sickle Cell (Hgb S) negative
☐ Irradiated
☐ Leukoreduced
☐ Washed
☐ Autologous
☐ Directed
☐ Volume Reduced

Duration of Transfusion:
☐ 30 minutes
☐ 1 hour
☐ 2 hours
☐ 3 hours
☐ 4 hours
☐ Bolus

Has Informed Consent Been Obtained? (Verify consent is attached to orders)
☐ Yes
☐ STAT

CONTINUED ON PAGE 2 ➔

NOTE: Epic Treatment/Therapy Plan Orders. To be scanned/attached to the appropriate Infusion Referral Order in Epic.
Prepare Blood Products (continued)

<table>
<thead>
<tr>
<th>Prepare &amp; Transfuse Platelets</th>
<th>Interval</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 1 Units</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ 2 Units</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Transfusion indications:
- Plts = 10K/µL for prophylactic bleeding control in therapy related, hypo-proliferative
- Plts = 20K/µL for central venous catheter placement
- Plts = 20K/µL for patients with sepsis or a bleeding diathesis
- Plts = 50K/µL in bleeding thrombocytopenic patients
- Plts = 50K/µL for patients having elective major non-neuraxial invasive surgery
- Plts = 100K/µL for patients having neuraxial invasive surgery
- Massive transfusion and bleeding
- Other

Special Requirements:
- CMV Negative
- HLA match
- Irradiated
- Leukoreduced
- Washed
- Volume Reduced

Duration of Transfusion:
- 30 minutes
- 60 minutes
- Bolus

Has Informed Consent Been Obtained? (Verify consent is attached to orders)
☐ Yes

STAT

Prepare & Transfuse Fresh Frozen Plasma

☐ 1 Units
☐ 2 Units

Transfusion indications:
- INR > 1.7 in a non-bleeding patient scheduled for surgery or invasive procedure
- INR > 1.7 with diffuse microvascular bleeding in a patient given greater than or equal to one blood volume
- Massive transfusion
- Reversal of warfarin anticoagulant therapy with major bleeding or impending surgery when oral/IV vitamin K or prothrombin complex concentrate (PCC) is not available
- Therapeutic plasma exchange
- Other

Duration of Transfusion:
- 30 minutes
- 60 minutes
- Bolus

Has Informed Consent Been Obtained? (Verify consent is attached to orders)
☐ Yes

STAT

Prepare & Transfuse Cryoprecipitate

☐ 1 Units
☐ 2 Units

Transfusion indications:
- Fibrinogen <= 100 mg/dL
- Fibrinogen <= 150 mg/dL AND active hemorrhage
- Dysfibrinogenemia WITH bleeding
- Other

Duration of Transfusion:
- 30 minutes
- 60 minutes
- Bolus

Has Informed Consent Been Obtained? (Verify consent is attached to orders)
☐ Yes

STAT

CONTINUED ON PAGE 3 ➔
Other Orders

<table>
<thead>
<tr>
<th>Order</th>
<th>Interval</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infusion Appointment Request</td>
<td>Once</td>
<td>1 treatment</td>
</tr>
<tr>
<td>Type and Screen (Required for RBC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AB/O (Required for all other products)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ONC NURSING COMMUNICATION 146</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vital Signs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notify Provider (Specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sodium chloride 0.9% bolus injection 50 mL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>acetaminophen (TYLENOL) tablet 650 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>diphenhydRAMINE (BENADRYL) capsule</td>
<td></td>
<td></td>
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<tr>
<td>Other medication with dose:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>meperidine (DEMEROL) injection 12.5 mg</td>
<td>PRN</td>
<td></td>
</tr>
<tr>
<td>furosemide (LASIX) injection 20 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete Blood Count without Differential</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prothrombin Time (PT with INR)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfusion Reaction Workup</td>
<td>PRN</td>
<td></td>
</tr>
</tbody>
</table>
| Other Labs: | Every ___ days | Until date: _______
| | Once | 1 year
| | | _____ # of Treatments

Telephone order/Verbal order documented and read-back completed. Practitioner’s initials ____________

NOTE: Unless Order is written DAW (dispense as written), medication may be supplied which is a generic equivalent by nonproprietary name.