Spectrum Health

# Physician's Orders BLOOD PRODUCTS - ADULT, OUTPATIENT, INFUSION CENTER

Page 1 to 3

Patient Name

DOB

MRN

Physician

FIN

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

| | Interval | Duration |
|---|---|---|

☐ 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.***

 

Spectrum Health

# BLOOD PRODUCTS - ADULT, OUTPATIENT, INFUSION CENTER *(CONTINUED)*



Patient Name

DOB

MRN

Physician

FIN

## Prepare Blood Products (continued)

| | Interval | Duration |
|---|---|---|
| ☐ Prepare & Transfuse Platelets | | |

- ☐ 1 Units
- ☐ 2 Units

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*** ➔

Spectrum Health

# BLOOD PRODUCTS - ADULT, OUTPATIENT, INFUSION CENTER *(CONTINUED)*



Patient Name

DOB

MRN

Physician

FIN

## Other Orders

| | | Interval | Duration |
|---|---|---|---|
| ☑ | Infusion Appointment Request<br>Status: Future, Expected: S, Expires: S+366, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Schedule one appointment | Once | 1 treatment |
| ☐ | Type and Screen (Required for RBC)<br>Status: Future, Expected: S, Expires: S+365, Routine, Lab Collect | | |
| ☐ | AB/O (Required for all other products)<br>Status: Future, Expected: S, Expires: S+365, Routine, Lab Collect | | |
| ☑ | ONC NURSING COMMUNICATION 146<br>Verify Consent - Blood Administration | | |
| ☑ | Vital Signs<br>Routine, Per policy, Starting S For Until specified, Obtain vital signs, including temperature, at the following intervals after start of the transfusion.<br>Ensure that the same route and thermometer is used throughout the transfusion.<br>1. 15 minutes after the start<br>2. 30 minutes after start<br>3. 1 hour after start<br>4. Continue every hour until transfusion is completed<br>5. 1 hour after the completion of the transfusion | | |
| ☑ | Notify Provider (Specify)<br>Routine, Until discontinued, Starting S For Until specified<br>Notify Provider:<br>Stop transfusion and notify provider & Blood Bank for any of the following: sudden vital sign changes, chills, abdominal / flank pain, shortness of breath, chest pain, restlessness, or infusion site pain. | | |
| ☑ | sodium chloride 0.9% bolus injection 50 mL<br>50 mL, Intravenous, See Admin Instructions, Starting S, For 1 Doses<br>Prime line. Hold sodium chloride during blood product transfusion. Flush line after completion of last unit. | | |
| ☐ | acetaminophen (TYLENOL) tablet 650 mg<br>650 mg, Oral, Once, Starting S, For 1 Doses<br>Administer 30min before blood products | | |
| ☐ | diphenhydrAMINE (BENADRYL) capsule<br>Oral, Once, Starting S, For 1 Doses<br>☐ 25 mg<br>☐ 50 mg<br>Administer 30min before blood products | | |
| ☐ | Other medication with dose:<br>_____ | | |
| ☐ | meperidine (DEMEROL) injection 12.5 mg<br>12.5 mg, Intravenous, for 5 Minutes, Once PRN, Shivering, Starting S, For 1 Doses | PRN | |
| ☐ | furosemide (LASIX) injection 20 mg<br>☐ 20 mg, Intravenous, for 2 Minutes, Once, Starting S, For 1 Doses, Administer after blood transfusion is completed.<br>☐ 20 mg, Intravenous, for 10 Minutes, Unscheduled, Starting S, For 2 Doses, Administer after each unit | | |
| ☐ | Complete Blood Count without Differential<br>Status: Future, Expires: S+365, Routine, Clinic Collect, Blood, Blood, Venous | | |
| ☐ | Prothrombin Time (PT with INR)<br>Status: Future, Expires: S+365, Routine, Clinic Collect, Blood, Blood, Venous | | |
| ☑ | Transfusion Reaction Workup<br>Status: Future, URGENT, Clinic Collect | PRN | |
| ☐ | Other Labs:<br>_____ | ☐ Every ___days<br>☐ Once | ☐ Until date: _____<br>☐ 1 year<br>☐ _____# 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.

| TRANSCRIBED: | | VALIDATED: | | ORDERED: | | |
|---|---|---|---|---|---|---|
| TIME | DATE | TIME | DATE | TIME | DATE | Pager # |
| | Sign | | R.N. Sign | | Physician Print | Physician |

**EPIC VERSION DATE:** 01/10/19

 