Perth and Smiths Falls District Hospital

PATIENT INFORMATION

Allergies: ______________________________

Medical Day Unit Blood Product Order Set

FAX completed form to Medical Day Unit – Perth Site at 613-267-2041 **AND**
To the Laboratory at 613-267-1862

☐ Standing Order ***Standing orders are only valid for **ONE** year from date below***
☐ Single Visit/Transfusion

Blood Transfusion History:

Previous Transfusion within 3 months ☐ Yes
Previous Transfusion Reaction ☐ Yes
Previous Transplant ☐ Yes
Previous Pregnancy within 3 months ☐ Yes
Any known antibodies ☐ Yes

Informed Consent

Informed consent signed: ☐ Yes ☐ Yes-with exceptions: ___________________ ☐ No

Transfusion of Blood Products

***Consider irradiated PRBCs if history of Hodgkin lymphoma, aplastic anemia, congenital T cell immunodeficiency, post-HSCT transplant, or history of treatment with Fludarabine/Cladribine/Pentostatin or alemtuzumab (Campath) ***

*** Routine transfusion of Red Blood Cells should be administered over 2 hours in most cases, 3 hours if risk for heart failure/transfusion-associated cardiac overload***

Red Blood Cells

☐ Packed RBCs Special Requirements: ☐ Irradiated ☐ Other: ____________________

☐ **Furosemide** ________ mg po to be given prior to transfusion
OR
☐ **Furosemide** ________ mg IV to be given prior to transfusion

☐ If hemoglobin is less than__________g/L **THEN** transfuse **one unit** of packed red blood cells IV over _________hour(s)

OR

☐ If hemoglobin is less than ________g/L **THEN** transfuse __________unit(s) of packed red blood cells IV each over _______ hour(s)

OR

☐ Transfuse ___________unit(s) of packed red blood cells IV each over ____________hour(s)

Platelets

☐ If platelet count is less than _______ x 10^9 cells/L **THEN** transfuse one adult dose of platelets IV over 30 to 60 minutes
OR
☐ Transfuse ____________ adult dose of platelets IV over 30 to 60 minutes

Physician Name: ____________	Signature: ____________	Date: D D / M M / Y Y Time: ______
Processed By: ____________	Verified By: ____________	2nd Check Signature: ____________
Date: D D / M M / Y Y Time: ______	Date: D D / M M / Y Y Time: ______	Date: D D / M M / Y Y Time: ______

☐ **Faxed to Pharmacy** Smiths Falls Site: 613-283-2957
Perth Site: 613-267-9748

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Vitals

☒ T, HR, RR, BP, SpO_2 prior to transfusion, 15 minutes after initiation, hourly and at end of transfusion
☒ T, HR, RR, BP, SpO_2 PRN during any transfusion reactions

Monitoring

☒ Monitor patient closely for transfusion reactions for the first 15 minutes of transfusion

Lab Investigations

Pre-Transfusion

☒ CBC (if not done within 7 days)

☒ Crossmatch ___________ units(s) red blood cells ☐ Other: ________________________

Post-Transfusion

☐ CBC ☐ Next morning post completion of transfusion ☐ Date/Time: __________________

Management of Blood Products Administration Transfusion Reactions

Premedication is not routinely recommended as it may mask or delay recognition of serious transfusion reactions

☒ Notify attending physician and Transfusion Laboratory
☒ If acetaminophen ordered, **max from all sources __________ mg in 24 hours (max 3,000 mg to 4,000 mg in 24 hours)**
☐ acetaminophen __________ mg PO/NG/PR 30 minutes prior to transfusion
☐ diphenhydr**AMINE** ________ mg PO/IV 30 minutes prior to transfusion

Additional Orders

____
____
____
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____
____

Physician Name: ____________	Signature: ____________	Date: D D / M M / Y Y Time: ______
Processed By: ____________ Date: D D / M M / Y Y Time: ______	Verified By: ____________ Date: D D / M M / Y Y Time: ______	2nd Check Signature: ____________ Date: D D / M M / Y Y Time: ______

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