Oregon Health & Science University Hospital and Clinics Provider's Orders PO7071 ADULT AMBULATORY INFUSION ORDER **Blood Transfusion Orders** Page 1 of 5	ACCOUNT NO. MED. REC. NO. NAME BIRTHDATE *Patient Identification*

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.
2. For Adventist patients: PARQ: Required_____(initials): "I have discussed the risks versus benefits of blood products designated below, as well as the risks and alternatives, with the patient/surrogate; they understand and agree to transfusion therapy
3. The Transfusion Blood Consent form must be completed annually.
4. To order blood transfusion products both an INFUSION PLAN and an ORDER PANEL must be ordered:
    a. INFUSION PLAN: "Blood Transfusion": includes pre-medications and treatment parameters
    b. ORDER PANEL: "CHO Blood Transfusion Orders": blood products and orders to transfuse
5. All patients automatically receive pre-storage leukodepleted, CMV safe red cell and platelet products. If irradiated is needed, please order under special needs section below.

LABS:

- ☐ CBC with differential, Routine, ONCE, every_____ (visit)(days)(weeks)(months) – Circle One
- ☐ Platelet count, whole blood, Routine, AS NEEDED, 1 hour post-platelet count if on Platelet Refractory Protocol
- ☐ Platelet count, whole blood, Routine, ONCE
- ☐ Type & Screen, Routine, ONCE
- ☐ Labs already drawn. Date: _____

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NURSING ORDERS:

1. VITAL SIGNS – Routine vital signs
2. TREATMENT PARAMETERS – ***(Attention Providers, please assign appropriate parameters)***
    a. Blood Transfusion:
        i. For Hemoglobin less than or equal to _____ g/dL, transfuse _____ units of packed red blood cells per OHSU transfusion policy (RBCs: 100 mL/hour x 15 minutes then increase to max rate 240 mL/hour for remainder of the unit if tolerated).
        OR
        ii. For Hematocrit less than or equal to _____ %, transfuse _____ units of packed red blood cells per OHSU transfusion policy (RBCs: 100 mL/hour x 15 minutes then increase to max rate 240 mL/hour for remainder of the unit if tolerated).
    b. Platelet Transfusion: For Platelet count less than or equal to _____, transfuse ___ units pheresis platelet product.
3. Review previous hemoglobin & hematocrit. If results not acceptable to blood bank due to internal dating policies, order CBC.
4. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes

PRE-MEDICATIONS: (Administer 30 minutes prior to infusion)
Note to provider: Please select which medications below, if any, you would like the patient to receive prior to treatment by checking the appropriate box(s)

- ☐ acetaminophen (TYLENOL) tablet, 650 mg, oral, ONCE, every visit
- ☐ diphenhydrAMINE (BENADRYL) capsule, 50 mg, oral, ONCE, every visit.
  Give either loratadine or diphenhydrAMINE, not both.
- ☐ loratadine (CLARITIN) 10 mg tablet, oral, ONCE AS NEEDED if diphenhydrAMINE is not given, every visit. Give either loratadine or diphenhydrAMINE, not both.
  Give either loratadine or diphenhydrAMINE, not both.

BLOOD PRODUCT(S): (Ordered using ORDER PANEL):

- **Packed Red Blood Cells (See below for special needs)**
    - Amount
        - ☐ _____ units
        - ☐ _____ mL
    - Duration
        - ☐ _____ hours/unit
        - ☐ _____ mL/hour
    - Interval
        - ☐ ONCE (appointment date: _____)
        - ☐ Every _____ days for _____ treatments. Begin on date:_____
    - Patient consented for transfusion, and documentation in med record?
        - ☐ Yes (fax consent to applicable infusion clinic)
        - ☐ No

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- **Pheresis Platelets (See below for special needs)**
  - Matched
    - ☐ HLA Matched
    - ☐ Crossmatched
  - Amount
    - ☐ _____ units
    - ☐ _____ mL
  - Duration _____ hours
  - Interval
    - ☐ ONCE (appointment date: _____)
    - ☐ Every _____ days for _____ treatments. Begin on date:_____
  - Patient consented for transfusion, and documentation in med record?
    - ☐ Yes (fax consent to applicable infusion clinic)
    - ☐ No
-
- **Frozen Plasma (See below for special needs)**
  - Amount
    - ☐ _____ units
    - ☐ _____ mL
  - Duration _____ hours
  - Interval
    - ☐ ONCE (appointment date: _____)
    - ☐ Every _____ days for _____ treatments. Begin on date:_____
  - Patient consented for transfusion, and documentation in med record?
    - ☐ Yes (fax consent to applicable infusion clinic)
    - ☐ No

- **Cryoprecipitate Pool (See below for special needs)**
  - Amount _____ pools (NOTE: 1 pool = 5 units. Usual adult dose = 2 pools)
  - Duration _____ hours
  - Interval
    - ☐ ONCE (appointment date: _____)
    - ☐ Every _____ days for _____ treatments. Begin on date:_____
  - Patient consented for transfusion, and documentation in med record?
    - ☐ Yes (fax consent to applicable infusion clinic)
    - ☐ No

- **Special Needs**
  - ☐ CMV REDUCED RISK (may use Leukoreduced or CMV seronegative)
  - ☐ CMV SERONEGATIVE
  - ☐ DIRECTED DONOR
  - ☐ IRRADIATED
  - ☐ LEUKOREDUCED
  - ☐ WASHED
  - ☐ PHENOTYPE MATCHED (rarely indicated)
  - ☐ OTHER _____

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ROUTINE MEDICATIONS:

☐ furosemide (LASIX) _____ mg IV, ONCE (after the first unit of blood product)

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
6. sodium chloride 0.9% bolus, 1000 mL, intravenous, Administer over 60 minutes, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax**: _____

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Central Intake:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient's preferred clinic location:

☐ **Beaverton**
OHSU Knight Cancer Institute
15700 SW Greystone Court
Beaverton, OR 97006
Phone number: 971-262-9000
Fax number: 503-346-8058

☐ **NW Portland**
Legacy Good Samaritan campus
Medical Office Building 3, Suite 150
1130 NW 22nd Ave
Portland, OR 97210
Phone number: 971-262-9600
Fax number: 503-346-8058

☐ **Gresham**
Legacy Mount Hood campus
Medical Office Building 3, Suite 140
24988 SE Stark
Gresham, OR 97030
Phone number: 971-262-9500
Fax number: 503-346-8058

☐ **Tualatin**
Legacy Meridian Park campus
Medical Office Building 2, Suite 140
19260 SW 65th Ave
Tualatin, OR 97062
Phone number: 971-262-9700
Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders

INFORMED CONSENT FOR BLOOD TRANSFUSION

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For long-term care of same diagnosis, consent is valid for up to 1 year, unless rescinded.

Starting date (date informed consent obtained): ____ /____ / 20___ End date: ____ /____ / 20___

My provider _____ has explained to me the potential need for
(Printed name and credentials of licensed independent provider)
blood transfusion in my medical treatment.

I have reviewed the information "What You Should Know About Blood Transfusion" on page 2 of this form, including information about the **benefits** of blood products, the **potential risks** of blood transfusion, and the **alternatives** to transfusion. My provider has asked me if I want a more detailed explanation about the transfusion and if I have any **additional questions**. My questions have been answered; the transfusion, alternatives and risks have been explained to me in substantial detail; and I am satisfied with the explanations. I have no additional questions about the procedure, treatments, other alternatives, methods of treatment and risks.

I consent to transfusion of blood products, including whole blood, red blood cells, platelets, plasma, cryoprecipitate, and/or granulocytes. I agree to accept the risks and consequences of blood transfusion and understand that I am free to change my mind regarding this transfusion at any time.

_____ / / : ☐am ☐pm
Signature of Patient/Legal Representative Date (required) Time (required)

_____ _____
Printed Name of Patient/Patient's Legal Representative Relationship of Legal Representative to Patient

☐- AN INTERPRETER WAS USED DURING THE INFORMED CONSENT PROCESS

_____
Printed Name of Qualified Interpreter

PROVIDER ATTESTATION

I, _____ discussed with this patient the detailed
(Printed name and credentials of licensed independent provider)
information outlined above and on page 2 of this form regarding the risks and benefits of blood product transfusion, as well as reasonable alternatives, including not transfusing blood products. The patient's questions were answered, and they verbalized understanding.

_____ / / : ☐ am ☐ pm
Signature of licensed independent provider Date (required) Time (required)

☐- TELEPHONE DISCUSSION BETWEEN PROVIDER AND PATIENT/LEGAL REPRESENTATIVE WAS USED TO OBTAIN INFORMED CONSENT

_____ _____ / / : ☐ am ☐ pm
Signature of provider's witness of telephone consent Print name Date (required) Time (required)

Refusal of Blood Transfusion
If you do NOT consent to blood transfusion, please complete the "Refusal of Blood Transfusion" form (MR-1418)

What You Should Know About Blood Transfusion

As part of your care at Oregon Health & Science University (OHSU), it may be necessary for you to receive blood products. Please read this information sheet and discuss any questions you may have with your doctor. Except in emergencies, **OHSU requires your written consent for transfusion**.

1. Benefits of blood products:

Your health care provider will consider ordering blood products to be given to you only when they believe the benefits to you are greater than the risks**.** Blood products your provider may use are:

- **Whole Blood** – to treat heavy bleeding.
- **Red Blood Cells** – to correct anemia; to increase oxygen delivery to cells throughout your body.
- **Platelets** – to help your blood to clot and reduce bleeding.
- **Plasma** – to help your blood to clot and reduce bleeding.
- **White Blood Cells** – to help you fight infection.

2. Potential Risks of Blood Transfusion:

Risks associated with blood transfusion are low.

- **Most common reactions, rarely dangerous (about 1 in 100 transfusions):** Chills, fever, itching, rash or hives.
- **Rare but more serious reactions:** Shortness of breath, wheezing, lung failure, low blood pressure (dizziness), very dark urine or blood in urine, kidney damage.
- **Very rare, but potentially life-threatening reactions (less than 1 in 100,000 transfusions):** Severe transfusion reaction with shock; bacterial infection; Mad Cow Disease; Hepatitis; HIV (AIDS); death.

To Outpatients Receiving Blood Products:

Reactions to blood are rare and most occur during transfusion or within a few hours after the completion of transfusion. After you go home, if you experience any of the symptoms listed above or think you might be having a reaction to blood, call your doctor or the clinic immediately. There will be someone on-call after hours. If your symptoms seem to be serious, go to an emergency room.

3. Blood Safety Measures:

The American **Red Cross** supplies most of the blood used at OHSU. The Red Cross carefully selects volunteer donors and tests the donated blood to minimize the risk of infection. OHSU relies on these procedures to insure safety. Before transfusion, **OHSU** will determine your blood group and Rh type, screen you for unusual antibodies, and crossmatch your blood with the blood you will receive to help assure the blood is compatible.

4. Alternatives to Red Cross donor blood:

There may be alternatives to blood transfusion available to you, depending on your condition and the time involved. Each alternative has its own risks. Some alternatives are:

- **Drugs to help you make blood (erythropoietin--EPO):** It takes weeks to months to replace red cells.
- **Your own blood (Autologous donation):** Donated before surgery or collected during surgery: Donations before surgery are made at the Red Cross 2 to 5 weeks before your operation. Giving your own blood does not guarantee you will not need other donor blood. It can also have side effects--you can have a reaction to donating and it can make you more anemic before surgery.
- **Drugs to reduce bleeding:** Some drugs can decrease bleeding during surgery, but cannot replace lost platelets or clotting factors.
- **Directed Donors:** OHSU will accept blood donated for you by relatives and friends provided their blood is compatible with yours and they meet standard Red Cross donation criteria. Directed donor blood has not been proven to be any safer than regular Red Cross donor blood and may be less safe. A “directed donor fee” is also charged for each directed donation. Preparation of the blood takes at least 4 to 5 days and blood from a relative must be irradiated to be safe for you.

  If you do not need Autologous or Directed Donor blood after it is collected for you, current Portland Red Cross and OHSU policies do not permit its transfusion to someone else.

5. Bloodless Surgery and Medicine:

OHSU respects the rights of those who refuse transfusion for religious or other reasons. A consultation can be arranged with the OHSU Patient Blood Management service to document your refusal of blood transfusion and explore alternatives to transfusion you may accept.