



Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO7071



ADULT AMBULATORY INFUSION ORDER
Blood Transfusion Orders

Page 1 of 4

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. 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
3. All Hematology/Oncology patients should automatically receive pre-storage irradiated, leukoreduced, CMV safe red cell and platelet products. All Renal transplant patients should automatically receive pre-storage leukoreduced, CMV safe red cell and platelet products.

LABS:

- CBC with differential, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One
- Type & Screen, Routine, ONCE (*for Tuality use only*)
- Labs already drawn. Date: _____

NURSING ORDERS:

1. VITAL SIGNS – Routine vital signs
2. TREATMENT PARAMETERS – (**Attention Providers, please assign appropriate parameters**)
 - a. Blood Transfusion: For Hematocrit less than or equal to _____ %, transfuse _____ units of packed red blood cells over _____ hours each.
 - b. Blood Transfusion: For Hemoglobin less than or equal to _____ mg/dL, transfuse _____ units of packed red blood cells over _____ hours each.
 - c. Platelet Transfusion: For Platelet count less than or equal to _____, transfuse _____ units pheresis platelet product.
3. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes



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Page 2 of 4

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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)

1. acetaminophen (TYLENOL) tablet, oral, ONCE, every visit
 - 650 mg
 - 325 mg
 - 500 mg
 - 1000 mg
2. diphenhydrAMINE (BENADRYL) injection, intravenous, ONCE, every visit
 - 25 mg
3. Other: _____
(dexamethasone, methylPREDNISolone, hydrocortisone, famotidine)

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

• **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



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Page 3 of 4

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• **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

• **Cryoprecipitate Pool (See below for special needs)**

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

ROUTINE MEDICATIONS:

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



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Page 4 of 4

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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:** _____

OLC Central Intake Nurse:

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



CO1407



**TRANSFUSION BLOOD
CONSENT**

Page 1 of 1

ACCOUNT NO.
MED. REC. NO.
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Patient Identification

_____/_____/_____: Oam Opm
Signature of Physician or designee Date (required) Time (required)

I have reviewed the points in the information sheet “What You Should Know About Blood Transfusion” including information about the **benefits** of blood products, the **potential risks** of blood transfusion and the **alternatives** to transfusion. My physician or practitioner 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 agree to accept the risks and consequences of blood transfusion and understand that I am free to change my mind at any time regarding this.

_____/_____/_____: Oam Opm
Patient's Signature Date (required) Time (required)

_____/_____/_____: Oam Opm
Witness's signature Date (required) Time (required)

If patient is unable to give consent or is a minor:

- () The patient is a minor
- () The patient is unable to consent because _____

I, _____ therefore consent for the patient.
Print name and relationship to patient

_____/_____/_____: Oam Opm
Consenter's signature Date (required) Time (required)

_____/_____/_____: Oam Opm
Signature of witness to consent Date (required) Time (required)

Note: If you do NOT consent please complete the “Transfusion Blood Refusal” 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 doctor will transfuse blood products only when he or she believes the benefits to you are greater than the risks. Blood products your doctor may use are:

- **Red Blood Cells** – to correct anemia; to increase oxygen delivery to the 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 of blood transfusion are low.

- **Most common reactions, rarely dangerous (about 1:100):** Chills, fever, itching, rash or hives.
- **Rare but more serious reactions:** Shortness of breath, wheezing, low blood pressure (dizziness), very dark urine or blood in urine, kidney damage.
- **Very rare, but potentially life-threatening reactions (less than 1:100,000):** 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 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. There will be someone on call after hours. If your symptoms seem to be serious ones, go to the emergency room.

3. Blood Safety Measures: The American **Red Cross** supplies most of the blood used at OHSU. The Red Cross carefully selects 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 blood alternatives 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 - 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. Because of this, if you don't use the donated blood, current Portland Red Cross and OHSU policy do not permit its transfusion to someone else. A "directed donor fee" is also charged for each directed donation. Preparation of the blood takes 4-5 days and blood from a relative must be irradiated to be safe for you.

5. Bloodless Medicine & Surgery:

OHSU respects the right of those who refuse transfusion for religious or other reasons. A consultation can be arranged with the OHSU Transfusion Service to explore alternatives to transfusion more fully.