

PROCEDURE CENTER

OUTPATIENT BLOOD TRANSFUSION ORDER FORM

Revised 10/5/2021

PATIENT NAME:		PATIENT DOB:
PATIENT PHONE #:		OFFICE PHONE #:
ORDERING PROVIDER:		OFFICE FAX #:
DIAGNOSIS/ICD-10 CODE: <i>(required)</i>		MA/NURSE:
REQUIRED		
CONSENT SIGNED BY PROVIDER	<input type="checkbox"/> Yes <input type="checkbox"/> No → <i>call Procedure Center at (970) 644-3319</i>	H&H RESULTS: <i>(date)</i> _____ Hg _____ g/dL Hct _____ %
TYPE and CROSS-MATCH DONE	<input type="checkbox"/> Yes <input type="checkbox"/> No → <i>fax T&C Order to CH Lab at (970) 644-3299</i>	PATIENT ALLERGIES:

CURRENT (2016) AMERICAN ASSOCIATION OF BLOOD BANKS (AABB) RECOMMENDATIONS:

for hemodynamically stable patients without active bleeding

- Hemoglobin <6 g/dL – Transfusion recommended except in exceptional circumstances.
- Hemoglobin 6 to 7 g/dL – Transfusion generally likely to be indicated.
- Hemoglobin 7 to 8 g/dL – Transfusion may be appropriate in patients undergoing orthopedic surgery or cardiac surgery, and in those with stable cardiovascular disease, after evaluating the patient's clinical status.
- Hemoglobin 8 to 10 g/dL – Transfusion generally not indicated, but should be considered for some populations (eg, those with symptomatic anemia, ongoing bleeding, and acute coronary syndrome with ischemia).
- Hemoglobin >10 g/dL – Transfusion generally not indicated except in exceptional circumstances.

TRANSFUSE: _____ UNIT(s) PRBCs PLATELETs FFP CRYOPRECIPITATESPECIAL HANDLING: IRRADIATEDAcetaminophen PO Pre-Med: (30 min before transfusion) 325mg 500mg 650mg 1000mgDiphenhydramine Pre-Med: (30 min before transfusion) PO IV 25mg 50mgFurosemide IV Push (given in between first and second unit) 10mg 40mg _____mg I authorize use of the Community Hospital Adult Hypersensitivity Reaction/Anaphylaxis Protocol

Provider's Signature: _____ Date: _____