Community HOSPITAL

PROCEDURE CENTER

OUTPATIENT BLOOD TRANSFUSION ORDER FORM

Revised 2/6/2020

Status:

DOB: Age:

Name:
Ref Phys:
Att Phys:
Prim Care Phys:

PATIENT NAME:	PATIENT DOB:
PATIENT PHONE #:	OFFICE PHONE #:
ORDERING PROVIDER:	OFFICE FAX #:
DIAGNOSIS/ICD-10 CODE: *(required)*	MA/NURSE:
CONSENT SIGNED BY PROVIDER : ☐Yes ☐No *(required) please call Procedure Center at (970) 644-3319 if consent form is needed*	H&H RESULTS: *(date)* _____ Hg_____ g/dL Hct_____ %
TYPE & CROSS-MATCH DONE: : ☐Yes ☐No *(required) if not done, please fax Type and Cross Match order to Community Hospital lab at (970) 644-3299*	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 ☐CRYOPRECIPITATE

SPECIAL HANDLING: ☐IRRIADIATED

Acetaminophen PO Pre-Med: (30 min before transfusion) ☐325mg ☐500mg ☐650mg ☐1000mg

Diphenhydramine Pre-Med: (30 min before transfusion) ☐PO ☐IV ☐25mg ☐50mg

Furosemide 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: _____

NAME: **DOB:**