ALLERGY ☐ NO ☐ YES WT.____________(kg) HT.______________
IF YES, PLEASE STATE___________________________________________

St. Cloud Hospital
CENTRACARE Health System

**OUTPATIENT ADULT BLOOD / BLOOD PRODUCT INFUSION ORDER – EPIC 1387**
**(BLOOD PRODUCT REVIEW WILL BE PERFORMED UNLESS EXCLUSION CRITERIA MET AS PER LIST ON REVERSE SIDE)**

1. **Schedule Transfusion for** ☐ Today ☐ Tomorrow ☐ 2 days from now ☐ 3 days from now

**All Outpatient Blood Administration orders will expire in 3 days**

2 **Transfusion consent signed** ☐ Yes ☐ No ☐ Completed previously

3 **Reason for Transfusion (See reverse side for indications)**

☐ Acute Blood Loss Anemia (hgb less than 10)
☐ Postoperative Anemia due to Perioperative Blood Loss
☐ Chronic Anemia (hgb less than 8 or symptomatic anemia)
☐ Hypotension
☐ To increase $O_2$ carrying capacity

☐ Thrombocytopenia
☐ Known factor deficiency (VII, XII, vWF)
☐ Fibrinogen less than 150
☐ PT (INR) PTT greater than 1.5 x normal

Describe other reasons not listed above ______________________________

4 **Special Instructions**:
Crossmatch ___________ (# units) of PRBC's
**Transfuse the following blood product(s):**
**Note: Prestorage leukoreduced blood products are considered "CMV safe";**
**CMV negative products are individually tested for CMV by the donor center.**

**RBC**
Leukoreduced Packed Cells, transfuse ___________ unit(s)
Irradiated, leukoreduced packed cells, transfuse __________ unit(s)
*Autologous red cells, transfuse _____________ unit(s)
**CMV tested negative, leukoreduced packed cells, transfuse __________ unit(s)
**Irradiated & CMV negative leukoreduced packed cells, transfuse __________ unit(s)

**PLATELETS**
Pheresed, leukoreduced platelets, transfuse ___________ unit(s) (1 unit = 6-8 pooled random donor platelets)
Irradiated, leukoreduced pheresis platelets, transfuse _______ unit(s)
**CMV tested negative, leukoreduced pheresed platelets, transfuse ______________ unit(s)
**CMV tested negative & irradiated, leukoreduced pheresed platelets, transfuse _________ unit(s)

**PLASMA**
Frozen plasma, transfuse _____________________ unit(s)
Cryoprecipitate, transfuse _____________________ unit(s)
**Granulocytes, transfuse _____________________ unit(s)
**Other product (e.g.: IVIG) ______________________________, transfuse ________________ (amount)

*Available if preoperative self-donated product has been received
** Product not routinely available and may result in transfusion delay necessitated by product shipment

**Rate of infusion** ____________________________________________
(individual units or containers must not exceed 4 hours infusion time)

5 **Post transfusion lab (order if appropriate)**
☐ Hgb ☐ Plt ☐ CBC (includes hgb & plt) ☐ PT(includes INR) ☐ PTT Other______________________ Time ________

6 Medications:
- NS 250 mL 15-100 mL/hr IV prn as directed PRBC and platelet transfusion

☐ Acetaminophen (Tylenol) 650mg (po) before transfusion x 1 dose. May repeat after _______hrs prn x 1 dose.
☐ Methylprednisolone Sodium Succinate _______mg IV before transfusion x 1 dose. May repeat after _______hrs prn x 1 dose.
☐ Dexamethasone (Decadron)___________ mg IV before transfusion x 1 dose. May repeat after ______hrs prn x 1 dose.
☐ Diphenhydramine (Benadryl) _______ mg IV before transfusion x 1 dose. May repeat after ______hrs prn x 1 dose.
☐ Furosemide (Lasix) __________ mg IV before transfusion x 1 dose.
☐ Furosemide (Lasix) __________ mg IV during transfusion x 1 dose.
☐ Furosemide (Lasix) __________ mg IV post transfusion x 1 dose
☐ Other ________________________________
☐ NA

7 I have discussed with the patient/family the nature and purpose of the proposed treatment, risks and consequences, reasonable and feasible treatment alternatives, and the prognosis if no treatment is given and have given the patient the opportunity to ask any questions they may have.

Orders **with a checkbox present** must be checked off to be implemented.
Orders **without a checkbox present** will be implemented unless stricken out.

**Physician Signature:** ____________________________________________

**Date:** ______________________________ **Time:** ______________________

St. Cloud Hospital
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# CONSENT FOR BLOOD/COMPONENTS TRANSFUSIONS (MEDICAL)

1. **(Print patient's name)**____________________________________ agree to get blood components.

2. **I have had a chance to talk with my doctor or health care team about:**
   a. Why I need a transfusion (medical condition) ______________________________.
   b. What a blood transfusion is.
   c. How a transfusion might harm me.
   d. My choices for treatment. The risks of those choices.
   e. How I might feel after. How quickly I should recover.
   f. I understand the team will be double checking who I am. This is to protect me.

**I have had my questions answered. I agree to the above plan.**

Signature: ________________________________________________
Patient's (or representative) signature Date Time

Reason if patient unable to sign: ________________________________________

**DOCTOR/PROVIDER:**
**I have answered the patient/family's questions about the proposed plan.**

Signature: ________________________________________________
Doctor/Provider Signature Date Time
(no other signature required if provider witnesses signature)

**WITNESS:**
**I have verified that the signature is that of the patient's or representative's. This form has been signed before the procedure.**

Signature: ________________________________________________
Witness Date Time

Signature: ________________________________________________
Interpreter Name (please print) Language/Organization Time

## Complications of Blood Transfusions – USA

| INFECTIOUS DISEASE | RISK PER UNIT |
|---|---|
| Hepatitis C Virus | less than 1 in 2,000,000 |
| Hepatitis B Virus | 1 in 200,000 |
| Human T-Lymphotropic Virus | 1 in 3,000,000 |
| Human Immunodeficiency Virus | 1 in 2,000,000 |
| Bacteria | less than 1 in million |
| Other Infection (Syphillis, Malaria, Chagas, Babesia) | less than 1 in million |

**REFERENCES:**
AABB Press, 2000
Dodd, Notari, Stramer
Transfusion 2002; 42:975

| OTHER COMPLICATIONS | RISK PER UNIT |
|---|---|
| Acute Hemolysis | 1 in 15,600 to 35,700 |
| Fatal Acute Hemolysis | 1 in 630,000 |
| Delayed Hemolysis | 1 in 4,000 to 11,600 |
| Fatal Delayed Hemolysis | 1 in 3.8 million |
| Febrile, Non-Hemolytic | 1 in 50 to 100 |
| Acute Lung Injury | 1 in 2,000 to 3,000* |
| Hives | 1 in 30 to 100 |
| Severe Anaphylaxis | 1 in 18,000 to 170,000 |
| Circulatory Overload | 1 in 3,000 to 12,000 |
| Transfusion-Associated Graft-VS-Host Disease | Unknown |

**REFERENCES:**
Popovsky (Silliman), etal, 1997*
AABB Press, 1996
Reviewed February 2005.

## Exclusions from Blood Review

**PHYSICIAN: Please note *If transfusion given outside of parameter, please justify use in medical record.**

Red Cell Transfusion
- Hgb less than 8 without active bleeding
- Hgb less than 10 with evidence of active bleeding
- Symptomatic anemia

Platelets
- Need pre & post levels
- less than 50,000 surgery cases or actively bleeding
- less than 20,000 med cases
- less than 100,000 in CABG, neurological or ophthalmological cases

Fresh Frozen Plasma
- Coags need pre & post

(PT PTT, INR greater than or equal to 1.5 and/or PTT with results greater than or equal to 1.5 times normal).
- Post-transfusion coags should show correction to INR less than or equal to 3.5
- Warfarin reversal in bleeding patient or patient needing surgery before pharmaceutical correction could occur, TTP and HUS patients, patients with deficient in ATIII, Protein C, Protein S or heparin cofactor II.

Cryo
- Fibrin glue, or Fibrinogen less than 100 mg.
- Known Factor VIII, XIII or VWF deficiency.