PHYSICIAN ORDER FOR RED BLOOD CELL TRANSFUSION

Name: __________________________________________
D.O.B.:__________________ MRN#__________________
Room # ________

Surgery †††††
ED †††††
Cancer Center †††††
Infusion Center †††††
Dialysis †††††
STL †††††
LTACH †††††

INDICATIONS: MUST CHECK AT LEAST ONE BOX BELOW. NOTE: These indications will be tracked and may be peer reviewed.

- Hematocrit less than or equal to 21% or hemoglobin less than or equal to 7 G/dl
- Hematocrit less than or equal to 24% or hemoglobin less than or equal to 8 G/dl in a patient with CAD and unstable angina/myocardial infarction/cardiogenic shock
- Rapid blood loss with greater than 30-40% of estimated blood volume (greater than 1500-2000 ml) not responding to appropriate volume resuscitation, or with ongoing blood loss
- The patient has been determined to be normovolemic and there is evidence to support the need for increased oxygen carrying capacity as evidenced by (indicate):_________________________________________________________________________
- Tachycardia, hypotension not corrected by adequate volume replacement alone
- PVO₂ less than 25 torr, extraction ratio greater than 50%, VO₂ less than 50% of baseline specify: __________________________
- Other: ___________________________________________ Reason: ______________________________________________

- The minimal effective dose of all blood products should be used. One unit of packed red cells in an adult will increase hematocrit by 3% and hemoglobin by 1 G/dl (8 ml/kg pediatric) SINGLE UNIT transfusion of packed red cells is often effective.

☐ PACKED RED BLOOD CELLS: Amount: ________________ Units ☐ RNICU/PEDS _____________ ml
☐ ROUTINE ☐ NOW ☐ STAT

☐ For Surgery on (date): _____________________________
☐ For Outpatient Infusion on (date):_________________________ Site: ______________________________

Infusion Rate: ☐ Infuse over 1.5 to 3.5 hours ☐ Rapidly Infuse Other rate ______________________________

SPECIAL NEEDS: Check each box below that applies (see information on reverse regarding special needs)

☐ Leuko-Reduced ☐ Irradiated ☐ CMV Negative ☐ Sickle Cell Negative ☐ Donor Directed ☐ Autologous

Most recent hemoglobin______G/dl or Hematocrit _______%

FAX COMPLETED ORDER FORM TO BLOOD BANK # (517) 364-2362

Faxed by (initials) ________ Date: ________ Time: ________

Doctor X Reg. No. Date Time

Noted by: x R.N. Date Time

PHYSICIAN’S ORDERS