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
- PVO$_2$ less than 25 torr, extraction ratio greater than 50%, VO$_2$ less than 50% of baseline specify: _________________________
- Other Indication: __________________________________________
TAKE-OUT FORM FOR RED BLOOD CELL TRANSFUSION

<table>
<thead>
<tr>
<th>Name: ___________________________________________</th>
<th>D.O.B.: ___________________</th>
<th>MRN#: ____________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room # ________</td>
<td>□ Surgery</td>
<td>□ ED</td>
</tr>
</tbody>
</table>

* 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.

- **PAICED RED BLOOD CELLS:** Transfuse: ________________ Units □ RNICU/PEDS ____________ ml
  - For Surgery on (date): __________________________
  - For Outpatient Infusion on (date): __________________________ □ Cancer Center □ Infusion Center

**Infuse over 1.5 to 3.5 hours OR** □ Rapidly Infuse  Other rate __________________________

**SPECIAL NEEDS:** Check each box below that applies

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

Most recent hemoglobin ______ G/dl or Hematocrit ______ %  On (Date): __________________________

**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 Indication: ________________________________________________________________

- □ UNCCROSSMATCHED (Emergency Release) Transfuse: _______ Units PRBC. Physician must sign below for Uncrossmatched Blood: I accept the responsibility for and release Blood Bank personnel of the responsibility for any adverse patient reaction resulting from this transfusion. I understand that additional testing will be performed as soon as possible and I will be notified of any significant problems discovered in such testing.

**THIS FORM MUST BE TAKEN TO THE BLOOD BANK TO PICK UP BLOOD PRODUCTS OR TUBED TO STATION #111**

- □ Consent signed per policy #2255
- □ Faxed by (initials) __________
- □ Date: __________ Time: __________

| R.N. Signature: ___________________ | Date: __________ | Time: __________ |

Sparrow
Lansing, MI

P-9754.00
(rev. 7/18/11)
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Part 2; Progress Notes

TAKE-OUT FORM FOR RED BLOOD CELL TRANSFUSION