ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PROVIDER

Allergies/Reactions:

ORDERS WITH CHECK BOXES
Providers are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

❑ MRCC, Puyallup Infusion Center	Fax: 253-697-5066	❑ MRCC, Gig Harbor Infusion Services	Fax: 253-530-8069
❑ Allenmore Ambulatory Infusion	Fax: 253-864-4052	❑ Deaconess Cancer and Blood Specialty Center	Fax: 509-755-5845
❑ MRCC, Auburn Infusion Services	Fax: 253-867-8282	❑ Valley Hospital Outpatient	Fax: 509-473-5782
❑ MRCC, Tacoma	Fax: 253-403-4991	❑ Capital Medical Center	Fax: 360-569-9759

Blood Products (Adult)

Patient Name:_____Requested Date of Service: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Patient Phone Number: (_____) _____ - _____ ❑ May leave message

Diagnosis: **ICD -10 Code:**

❑ _____ ❑ _____

❑ _____ ❑ _____

Required:

If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

- H&P with documentation to support above diagnosis including ICD-10 code and supporting labs
- **Code Status:** Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.
  - ❑ Alternate Code Status _____
- **Consent obtained:** ❑ Yes ❑ No (send DOCUMENTATION of consent with order)
- **Baseline** CBC

Baseline labs to be drawn at time of infusion:

❑ CBC ❑ Type and Screen ❑ Blood Type (only required for new non-RBC patients)

See MHS Transfusion Guidelines for ordering criteria

Red Blood Cells (RBCs): _____unit(s) Set Up
Transfuse _____ unit(s)

- ❑ Is Hgb <7 g/dL or Last Hct <21%?
  - ❑ If No, state order rationale: _____
- ❑ Leuko-reduced, CMV Safe
- ❑ Leuko-reduced and Irradiated RBCs, CMV safe
- ❑ Other _____

Platelet (PLT): _____ unit(s) Set Up; Transfuse _____ unit(s)

- ❑ Is Plt <10/mcL?
  - ❑ If No, state order rationale: _____
- ❑ Platelet, all CMV safe
- ❑ HLA-matched platelets
- ❑ Other_____

Pre-Transfusion Medications:

- ❑ Acetaminophen 650 mg po every 4 hours prn, Indication _____
- ❑ Diphenhydramine (Choose One):
  - ❑ 25 mg PO x 1 dose prior to infusion
  - ❑ 25mg IV x 1 dose prior to infusion
- ❑ Loratadine 10 mg po x 1 dose
- ❑ Furosemide _____ mg IV in between units

Nursing:

- ☑ Vital Signs: Assess vital signs per MHS Blood Administration Policy
- ☑ Contact provider if systolic BP >180; diastolic BP >100; systolic BP <90; HR >100; temp >38C (100.4F)
- ☑ IV Access: Access and/or maintain IV site in accordance with MHS IV Therapy P&P: Peripheral IV Device Site Selection, Insertion, Maintenance, and Discontinuation; and Maintenance of Central Venous Catheters-Flushing, Dressing Changes and Removal.

If suspected transfusion reaction, STOP transfusion and contact ordering provider.
Nursing will follow MHS Transfusion Reaction Protocol (see Blood Administration Policy).

Provider Signature	Print Name	Date	Time

Another brand of drug, identical in form and content, may be dispensed unless checked ❑

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order

BLOOD PRODUCTS (Adult)

MultiCare