

ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

Fax all infusions to: 833-380-8800

Please mark the appropriate infusion center:

- Allenmore Infusion Center
- Auburn Infusion Center
- Gig Harbor Infusion Services
- Puyallup Infusion Center
- DHEC Infusion Center
- North Spokane Infusion Center
- North Star Lodge Infusion Center

ORDERS WITH CHECK BOXES

When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

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 

