Outpatient Blood Products Transfusion Order

(All red blood cells and platelets at LMH are leukoreduced)

Patient Name:_____ Date of Birth:____/ ____/_____

Date/Time to be Transfused: _____/_____ Location: ☐ TPC ☐ Oncology

Pre-medications:_____

Diet: _____ Activity: _____

Allergies: _____ Code Status: _____

Nursing/To Include IV Access: _____ Other: _____

☐ **Packed Red Blood Cells** (TYPE & CROSSMATCH)

Transfuse _____ unit(s) *Special Requirements*: ☐ Irradiated ☐ CMV Negative ☐ Washed

Note: Administer red cells 1 unit at a time in non-urgent settings. The patient should be assessed before the administration of additional units.

Diagnosis: _____

Indication:

☐ Hemoglobin less than 7 gm/dL
☐ Hemoglobin less than 8 gm/dL with symptomatic cardiovascular disease
☐ Hemoglobin less than 8 gm/dL with current malignancy
☐ Pre-Operative hemoglobin less than 8 gm/dL

☒ A pre-transfusion Hgb/Hct will be performed at LMH if not already done here within the past 24 hours **(HGB/HCT).**

☐ **Apheresis platelets** (ABO & Rh if necessary) (ABORH)

Transfuse _____ unit(s) *Special Requirements*: ☐ Irradiated ☐ CMV Negative ☐ Washed

Diagnosis: _____

Indication:

☐ Platelet count less than 10,000
☐ Platelet count less than 20,000 in a stable non-bleeding patient undergoing a minor invasive procedure
☐ Platelet count less than 50,000 in patient scheduled for major surgery
☐ Platelet count less than 50,000 in non-bleeding patient having a lumbar puncture
☐ Bleeding in a patient with qualitative platelet defect (caused by drugs or otherwise) regardless of count

☒ A pre-transfusion platelet count will be performed at LMH if not already done here within the past 24 hours **(PLT).**

☐ **Fresh Frozen Plasma** (ABO & Rh if necessary) (ABORH)

Transfuse _____ unit(s)

Note: Vitamin K should always be considered before FFP to reverse Warfarin effect unless need for correction is urgent.

Diagnosis: _____

Indication:

☐ INR >2.0 and significant hemorrhage
☐ INR >2.0 prior to procedure
☐ Emergent reversal of warfarin
☐ Hereditary angioedema
☐ Plasma Exchange (HUS or TTP)

☒ INR or PTT will be performed at LMH if not already done here within the past 24 hours. **Please circle test indicated (PT/PTT).**

Provider Signature: _____ **Date/Time:** _____

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Patient Label