Eaton Rapids
Medical Center
517.663.2671 • www.eatonrapidsmedicalcenter.org
1500 South Main • Eaton Rapids, MI 48827

Patient First and Last Name:

Date of Birth:

Outpatient Transfusion Orders

Unless otherwise clearly specified hereon in writing, any orders for a drug identified below by its proprietary name, may be filled with its formulary identical

Ordering Physician: _____ Contact Number: _____
Diagnosis: _____Diagnosis Code: _____
Height: _____Weight: _____
Allergies: _____

Obtain Consent for Transfusion of Blood Component(s) ordered below
Laboratory results pertinent to Transfusion and date obtained: Hgb/HCT-_____ Date-_____
Platelet-_____ Date-_____Other-_____ Date-_____
Type and Screen, Crossmatch as required and give:
___Unit(s) Leukocyte Reduced Packed Red Blood Cells **(Check if required)** ☐CMV sero-negative ☐Irradiated
___Unit(s) Apheresis Platelets **(Check if required)** ☐CMV sero-negative ☐Irradiated
___Unit(s) Fresh Frozen Plasma _____
___Unit(s) Cryoprecipitate _____
___Unit(s) Factor VIII _____
___Other: _____

Check box or specify below:

- ☐ Initiate 18gauge or 20gauge IV _____
- ☐ Access PICC or Port for transfusion and flush per protocol
- ☐ 0.9 Normal Saline IV fluid with appropriate blood/blood component infusion set
- ☐ Diet: _____
- ☐ Activity:_____
- ☐ H&H one hour post-Leukocyte Reduced Packed Red Blood Cell transfusion
- ☐ Platelet count one hour post-Platelet transfusion
- ☐ Medications:_____
  _____
  _____

Discharge when the following criteria are met:

- ☐ Discharge patient after post-transfusion H&H or post-platelet labs are drawn
- ☐ Discharge patient after post-transfusion H&H or post-platelet results are obtained
- ☐ Discharge patient after post-transfusion H&H or post-platelet results are discussed with physician
- ☐ Other: _____

Above orders and Provider acknowledgement of <u>Informed Consent</u> for Blood and or Blood Component Administration

By signing this form, I certify that I or my physician associate has explained to the patient or his/her representative:

- The diagnosis, nature and purpose of the transfusion.
- The risks and benefits of the transfusion.
- The patient's prognosis if the proposed treatment is not given.

I or my physician associate has given the patient or his/her authorized representative the opportunity to ask questions, and believe all questions have been answered to the patient and/or his/her representative's satisfaction.

Date: _____ Time: _____ Signature of Physician: _____

Fax signed orders to 517-663-8615
After 4 p.m. or on weekends fax to 517-663-9436