PHYSICIAN ORDER FOR RED BLOOD CELL TRANSFUSION

Name: _____ **D.O.B.:**_____ **MRN#**_____

Room # _____ ☐ **Surgery** ☐ **ED** ☐ **Dialysis** ☐ **STL** ☐ **SSH**

- 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.

☐ **PACKED 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

☐ PVO_2 less than 25 torr, extraction ratio greater than 50%, VO_2 less than 50% of baseline specify:_____

☐ **Other Indication:** _____

☐ **UNCROSSMATCHED (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.*

Doctor	**Reg. No.**	**Date**	**Time**
X			
Noted by:		**Date**	**Time**
x **R.N.**			

FAX COMPLETED ORDER FORM TO BLOOD BANK # (517) 364-2362

Faxed by (initials) _____

Date: _____ Time: _____

TAKE- OUT FORM FOR RED BLOOD CELL TRANSFUSION

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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:**_____