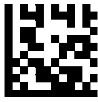
COOLEY DICKINSON HOSPITAL
MASSACHUSETTS GENERAL HOSPITAL AFFILIATE

(Patient Sticker)



PHYSICIAN ORDER SET :

MEDICAL DAY CARE Order Form
Blood Transfusions

Patient: ______________________________ DOB: ____________ Gender: ____________

Patient Phone: ______________________________ Height: ____________ Weight: ________ lb kg

Diagnosis: ______________________________ ICD-10 Code: __________

Injection(s) Start Date: __________

Provider Facility Name: ______________________ Provider Facility Address: ______________________

Ordering Provider: __________________________ Order Date: __________

Signature: ______________________________

Complete, sign, and fax this document to: ***CDH Central Scheduling at 413-582-2183.***

**Please include H&P/ current medications list/ allergies **

☐ **Signed Consent Obtained** ____ Yes → *fax signed consent form along with this order form*

Pre-transfusion Lab order:

☐ **Type & Screen (ABO, Rh, Antibody Screen)** Once __ Lab Collect

- Specimen type: ____Blood _____ Blood, Arterial
- Length of infusion time: ______________________________
- Performing Lab: ______________________________________

Additional Lab Info:

Blood Administration

☐ **Red Blood Cells** Once ___ # of units

- Indications: _____ Active bleeding _____ Signs/symptoms of anemia _____ Active myocardial ischemia _____Hct <21%
  _____ Intra-op _____ Hct <24% (Onc only) Other ______________________
- Modification request: ____ Irradiated _____ Leukoreduced Washed RBC
- Length of infusion time: ________________________

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☐ **Cryoprecipitate** Once ___ # of bags *(1 bag = 5 units)*

- Indications: ____ active bleeding ____ fibrinogen <100 mg/dL Other ________________________
- Length of infusion time: _______________________________

☐ **Plasma** Once ___ # of units

- Indications: ____ INR > 1.5 ___ Intra-op Other ___________________________
- Modification request: ____ Cryo-reduced ____ IgA deficient
- Length of infusion time: _______________________________

☐ **Platelets** Once ___ # of units *(1 unit = 1 bag = 1 Adult dose)*

Standard dose (adults & children): >20 kg = 1 unit <20 kg= 10-15 mL/kg

- Indications: _____ Perioperative _____ Platelet Dysfunction _____ Platelet count < 10 _____ Intra-op

  Other __________________________
- Modification requests: ____ Irradiated ____Leukoreduced ____CMV-negative _____ IgA Deficient _____Volume Reduced ____ HPA Selected Neg _____HLA Matched _____Single Donor Other ____________________________

Additional Blood Admin Info:

Medications

☐ **Acetaminophen (TYLENOL) tablet 325 mg** Oral Mild Pain Freq: ____every 6 hours PRN ______________Other Freq.

Additional Info:

☐ **Furosemide (LASIX) Injection syringe 20 mg** Intravenous Freq: ___ Once ___Twice ______________Other Freq

Additional Info:

☐ **Diphenhydramine (BENADRYL) tablet 25 mg** Oral Once Other: __________________

Additional Medication Info: