PHYSICIAN ORDER SET:
MEDICAL DAY CARE Order Form
Blood Transfusions

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| 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
- 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: ___________________