KVH
Klickitat Valley Health

Outpatient Blood & Platelet Transfusion Order Set

Phone: 509-772-2695 Fax: 509-773-3354

General

Patient Name _____ DOB _____ Height _____ Weight _____ Phone #_____

Order Start Date _____ Order Expiration Date _____

Allergies: _____

Guidelines for Ordering:

1. Send **FACE SHEET** and **H&P** or most recent chart note.
2. Send pertinent labs, such as hemoglobin level, (must be within last 7 days).

DIAGNOSIS CODE: **If using 'Other' must include ICD10 code**

☐ D64.9 Anemia ☐ Other: _____

Nursing Orders

☒ Ensure Blood Consent is signed

IV ACCESS: ☐ Place peripheral IV ☐ Access Implanted Port

If nurse to access implanted port please complete Port Access Order Set as well

☒ Vital Signs: baseline, prior to each unit of blood/blood product, at 15 minute check with each unit of blood/blood product, with completion of each unit of blood/blood product, and prior to discharge. Hold patient for 30 minutes post-transfusion to observe/monitor for adverse reaction.

Pre-Medications:

☐ Acetaminophen (Tylenol) 650mg PO x1 dose ☐ Diphenhydramine (Benadryl) 25mg PO x1 dose

Transfusion Orders

☐ Packed Red Blood Cells *(Leukocyte Reduced)*: _____ unit(s) per KVH 'Blood and Blood Products: Consent, Administration, Transfusion Reaction and Documentation' policy.

☐ Platelets (*Pathogen-Reduced, Rh-Matched*): _____ unit(s) per KVH 'Blood and Blood Products: Consent, Administration, Transfusion Reaction and Documentation' policy.

☒ Normal Saline 0.9% 500mL IV to run with transfusion per KVH 'Blood and Blood Products: Consent, Administration, Transfusion Reaction and Documentation' policy.

☐ Other: _____

_____

IF TRANSFUSION REACTION OCCURS

☒ Stop transfusion immediately, follow Transfusion Reaction Protocol and call ordering provider (call hospitalist on duty if after hours). Possible admission to the emergency department for further evaluation/treatment.

Additional Orders

☐ _____

_____

_____

Patient Name:
DOB:

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Ordering Facility/Provider Information

By signing below, I affirm the following:

I am responsible for the care of the patent identified on this form.

I hold an active, unrestricted license to practice medicine in _____ *(specify state)*

My provider license number is # _____ and I am acting within my scope of practice and authorized by law to order the treatment plan described above for the patient identified on this form.

Provider Signature: _____ **Date** _____

Printed name: _____ **Phone:** _____ **Fax:** _____

KVH Provider Co-signature:

**Required for all external orders*

Provider Signature: _____ **Date** _____

Printed name: _____

Patient Name:
DOB: