Outpatient Blood Transfusion Order Set

Klickitat Valley Health
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.

DIAGNOSIS CODE:

☐ D64.9 Anemia ☐ Other: _____

Labs:

☐ Pertinent Labs (must be within last 7 days, **please send copy if ordering from external facility**):

_____

Nursing Orders

☒ Ensure Blood Consent is signed

IV ACCESS: ☐ Place large bore 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, at 15 minute check with each unit of blood, with completion of each unit of blood, 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

☐ Transfuse ____ unit(s) of Packed Red Blood Cells per KVH 'Blood and Blood Products: Consent, Administration, and Transfusion Reaction' protocol.

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

☐ If transfusing multiple units of PRBC's, administer furosemide ____ mg IV ONCE, after first unit of PRBC's. Hold if SBP <100 or DBP <60.

IF TRANSFUSION REACTION OCCURS

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

Additional Orders

☐ _____

_____

_____

OUTPATIENT NURSE- PLACE STICKER HERE

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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 physician license number is # _____ and I am acting within my scope of practice and authorized by law to order infusion of the medication 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: _____

OUTPATIENT NURSE- PLACE STICKER HERE