




<p style="text-align: center;">THE UNIVERSITY OF KANSAS HOSPITAL 3901 Rainbow Boulevard Kansas City, Kansas 66160</p> <p style="text-align: center;">PHYSICIAN'S ORDER FORM</p>	<p>Do not write in this box</p>  <p>D T O O 1 7</p>	<p>PATIENT LABEL</p>
DATE & TIME	#	<p>ORDERS ADULT BLOOD TRANSFUSION ORDER SET</p>
		<p>Legend:</p> <ul style="list-style-type: none"> • Bullets indicate orders will be done. Draw one line through any orders that are not needed. <input type="checkbox"/> Boxes are optional and must be checked to be considered an order.
		<p>Reference: Hebert PC, Wells G, Blajchman MA et al <i>A multicenter, randomized, controlled clinical trial of transfusion requirements in critical care. NEJM 1999; 340:409-417.</i></p> <p>Abdel-Wahab OI, Healy B, Dzik WH. <i>Effect of Fresh-frozen plasma transfusion on prothrombin time and bleeding in patients with mild coagulation abnormalities. Transfusion 2006;46:1279-1285.</i></p>
		<p>Attending Physician: _____ Pager: _____</p> <p>Resident Physician: _____ Pager: _____</p> <p>ICD-9 Code: _____</p>
		<p>Indications for Special product requirements:</p> <p><u>Irradiated</u> – Bone marrow, cord blood or peripheral blood progenitor cell transplants, intrauterine transfusion, neonates <1200 grams or following intrauterine transfusions or other severely immunosuppressed patients. Products will additionally be irradiated if donated by a blood relative or when platelets are selected by HLA matching or crossmatching.</p> <p><u>CMV negative</u> – allogeneic bone marrow, cord blood or peripheral blood progenitor cell transplants where donor and recipient are CMV seronegative</p> <p><u>Washed</u> – prevention of anaphylaxis in IgA deficiency or other patients with antibodies to plasma proteins</p> <p><u>Sickle cell negative</u> – Sickle cell disease, neonatal RBC exchange and intrauterine transfusion.</p>
1.		<p>Packed Red Blood Cells, Leukoreduced: Most recent hgb ____g/dL or hct ____% (within 24 hours)</p> <ul style="list-style-type: none"> • Special product requirements: <input type="checkbox"/> Irradiated <input type="checkbox"/> Washed <input type="checkbox"/> CMV negative <input type="checkbox"/> Sickle Cell negative <input type="checkbox"/> Hold ____ units for procedure or other possible need (please specify): Date: _____ Procedure/Other: _____ <input type="checkbox"/> Transfuse ____ units. One unit of packed red cells in an adult will increase hct by approximately 3% and hgb by 1 g/dL. Please order one unit and evaluate clinically before ordering additional units. <p>Indications for transfusion (must select one):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hematocrit ≤ 21% or hemoglobin ≤ 7 g/dL <input type="checkbox"/> Hematocrit ≤ 24% or hemoglobin ≤ 8 g/dL in a patient with coronary artery disease and unstable angina/ myocardial infarction/ cardiogenic shock <input type="checkbox"/> Rapid blood loss with > 30- 40% of estimated blood volume (>1500- 2000 mL) not responding to appropriate volume resuscitation, or with ongoing blood loss. <input type="checkbox"/> The patient has been determined to be normovolemic and there is evidence to support the need for increased oxygen carrying capacity as witnessed by (indicate): <ul style="list-style-type: none"> <input type="checkbox"/> Tachycardia, hypotension not corrected by adequate volume replacement alone <input type="checkbox"/> Sepsis protocol <input type="checkbox"/> Mixed Venous Oxygen Saturation (SvO2) <70% <input type="checkbox"/> Other - specify _____ <input type="checkbox"/> Research Protocol/Other - specify _____
		<p>ADULT BLOOD TRANSFUSION ORDER SET</p>
		<p>(Page 1 of 2)</p>



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PATIENT LABEL

PHYSICIAN'S ORDER FORM

DATE & TIME	#	ORDERS ADULT BLOOD TRANSFUSION ORDER SET
	2.	<p>Apheresis Platelets, Leukoreduced: Most recent platelet count _____ / μL (within 24 hours) Special product requirements: <input type="checkbox"/> Irradiated <input type="checkbox"/> CMV negative <input type="checkbox"/> Crossmatched <input type="checkbox"/> Hold _____ units for procedure or other possible need (please specify): Date: _____ Procedure/Other: _____ <input type="checkbox"/> Transfuse _____ units <i>A single dose of platelets (adult: one apheresis product) will increase the platelet count by 30,000-60,000/μL. Transfusion of more than one unit may require additional testing and/or review.</i></p> <p>Indications for transfusion (must select one):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Platelet count \leq 10,000/ μL prophylactically in a patient with failure of platelet production <input type="checkbox"/> Platelet count \leq 20,000/ μL and signs of hemorrhagic diathesis (petechiae, mucosal bleeding) <input type="checkbox"/> Platelet count \leq 50,000/ μL in a patient with (indicate): <ul style="list-style-type: none"> <input type="checkbox"/> Active hemorrhage <input type="checkbox"/> Invasive procedure (recent, in-progress, planned) specify _____ <input type="checkbox"/> Platelet dysfunction as documented by- specify _____ <input type="checkbox"/> Research Protocol/Other - specify _____
	3.	<p>Plasma: Most recent coagulation studies: INR ____ PTT ____ Fibrinogen _____ (within 24 hours) <input type="checkbox"/> Hold _____ units for procedure or other possible need (please specify): Date: _____ Procedure/Other: _____ <input type="checkbox"/> Transfuse _____ units <i>A dose of two units of plasma is usually adequate to correct a coagulopathy.</i></p> <p>Indications for transfusion (must select one):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Abnormal coagulation studies and significant hemorrhage <input type="checkbox"/> Prophylactic use for INR > 2.0 or INR >1.8 prior to a procedure – specify _____ <input type="checkbox"/> Emergent reversal of coumadin <input type="checkbox"/> Research Protocol/Plasmapheresis/Other - specify _____
	4.	<p>Cryoprecipitate: Most recent coagulation Studies: INR ____ PTT ____ Fibrinogen _____ (within 24 hours) <input type="checkbox"/> Transfuse _____ units. <i>A standard adult dose is 10 bags. (product may be available in pre-pooled packs of 5 and 1 pooled 5 pack may be sufficient).</i></p> <p>Indications for transfusion (must select one):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fibrinogen \leq 100 mg/ dL <input type="checkbox"/> Fibrinogen \leq 150 mg/dL with active hemorrhage <input type="checkbox"/> Research Protocol/Other - specify _____

Physician Signature: _____ Pager: _____ Date: _____ Time: _____

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