Riverbend Medical Center Regional Infusion Center (RIC)
3377 Riverbend Drive Suite 502/510
Springfield, Oregon 97477
Phone 541-222-6280 Fax 541-349-8006

Other Blood Product Transfusion Order (v.05/24/2024)

Allergies: _____

Diagnosis Code **and** Check Appropriate Indication Below:

Diagnosis/ Indication:_____

- ☐ INR > 1.7
- ☐ PTT > 1.5x normal (not due to heparin)
- ☐ Factor Deficiencies
- ☐ Plasma exchange
- ☐ Neurosurgical procedure
- ☐ Disseminated intravascular coagulopathy
- ☐ Other (specify) _____

Fax copy of Face Sheet and current medication/ allergy list with this order to 541-349-8006

Admit:

☐ One time infusion order

☐ Series infusion patient:

Frequency: _____, Duration: _____

■ Vital Signs: Per PeaceHealth policy "Blood and Blood Product Administration Policy and Procedure"

Access:

☐ Insert peripheral IV site with saline lock

☐ Access Central Venous Access Device (CVAD) per "CVAD Insertion and Maintenance Policy"

☐ Alteplase 2 mg/ 2 mL PRN poor blood return from CVAD, may repeat x1, declotting with thrombolytic agent procedure

■ Labs: Type & Screen

Medications:

☐ Diphenhydramine _____ mg PO x 1 on arrival

☐ Acetaminophen _____ mg PO x 1 on arrival

☐ Furosemide _____ mg IV x 1 in between units 1 and 2 (during transfusion)

Emergency Medications: (May give emergency medications IM if IV route unavailable)

■ DiphenhydrAMINE (BENADRYL) 25 to 50 mg IV as needed for mild to moderate drug reactions (flushing, dizziness, headaches, diaphoresis, fever, palpitations, chest discomfort, blood pressure changes (>/= 20 points in SBP), nausea, urticaria, chills, pruritic).

-- Administer 25 mg IV once, if reaction does not resolve in 3 minutes may repeat 25 mg IV dose for a total of 50 mg and contact provider.

■ MethylPREDNISolone sodium succinate (Solu-MEDROL) 125 mg IV once as needed for shortness of breath, continued symptoms of mild to moderate drug reaction (flushing, dizziness, headaches, diaphoresis, fever, palpitations, chest discomfort, blood pressure changes (>/= 20 points in SBP), nausea, urticaria, chills, pruritic) that worsen or persist 5 minutes after administration of diphenhydramine (Benadryl). Contact provider if given.

■ Epinephrine 0.3 mg IM once for anaphylaxis. If reaction does not resolve in 3 minutes may repeat 0.3 mg IM dose for a total of 0.6 mg. Avoid use of hand, foot, leg veins in elderly patient and those with occlusive vascular disease. Contact provider if given.

■ Famotidine (PEPCID) 20 mg IV once as needed for infusion/ allergic reaction.

☐ Give:

☐ Fresh Frozen Plasma _____ units over 30 minutes/ unit

■ Cryoprecipitate _____ pools over 15 minutes/ pool

Transfuse per PeaceHealth policy "Blood and Blood Product Administration Policy and Procedure

Patient has been consented for transfusion and documentation in medical record.

Patient name: _____

DOB: _____

Height _____ Weight _____

Provider printed name: _____

Provider signature: _____

Date: _____ Time: _____

PROPOSED TREATMENT

I understand that I may need a transfusion as part of my treatment. This transfusion may be needed for blood loss due to injury, hemorrhage, disease or surgery, treatment for cancer, leukemia, or various blood diseases, replacing blood or blood products that my body is unable to produce.

Blood products may include any of the following parts depending on my medical condition.

- Red cells to carry oxygen to tissues or organs
- Platelets, plasma, and factor concentrates to promote clotting
- White cells to fight infection

I understand that when my health care provider decides I need a transfusion, a small blood sample will be collected and labeled for testing before any transfusion to ensure I am receiving a unit matched for me.

RISKS AND SIDE EFFECTS

There are risks and possible side effects (reactions) caused by a transfusion of blood or blood products. Known reactions to transfusions include, but are not limited to:

- Bruising, chills, fever, skin rash, and hives.

Less common but more serious reactions include:

- Fluid in the lungs, shortness of breath.

Very rare but severe reactions include kidney failure, low blood pressure and shock, transmissions of diseases such as hepatitis, HIV, or AIDS, and developing a bacterial infection.

❑ GENERAL INFORMATION FOR MINORS

Parent or Guardian Initial: _____

As the parent/guardian of a minor child I understand that the provider(s) treating my minor child will make best efforts to respect my beliefs regarding the transfusion of blood products. The providers will make their best efforts to treat my minor child without the use of blood.

CONSENT FOR TRANSFUSION OF BLOOD PRODUCTS

My health care provider has explained that I may benefit from a transfusion of blood products. He/she has explained the risks and possible side effects of receiving blood or blood products as described above.

I understand that PeaceHealth Transfusion Services and the blood and blood product supplier take safety measures to make the risks as small as possible.

Other options to transfusion, including no treatment, have been explained to me.

I am satisfied with the way the benefits, risks, possible side effects and other options were explained to me and that I have had a chance to get answers to my questions. My questions were answered to my satisfaction.

I understand the contents of this form and I agree to the transfusion of blood and blood products.

Signature of patient		Date	Time
Signature of person authorized to sign for patient – Relationship		Date	Time
Caregiver (witness) signature	3x3	Date	Time
Provider signature	3x3	Date	Time

For staff use only:

Was Interpreter utilized? Yes No

If yes (and remote), Interpreter name: _____

Interpreter #: _____

If yes (and present), _____

Interpreter signature 3x3 (if applicable) Date Time

REFUSAL OF TRANSFUSION OF BLOOD PRODUCTS

❑ I refuse blood products to be transfused.

❑ I refuse blood products except for:

❑ _____ ❑ _____ ❑ _____ ❑ _____

- I request this even though in the opinion of my health care provider, such blood products may be needed to preserve life or promote recovery.
- I understand that refusal to consent to life-saving treatment for my minor child based on religious beliefs may not be protected under federal or state laws and that I may be held criminally liable if my minor child is harmed because of my refusal
- I further understand that my minor child's medical team may seek a court order to provide necessary life-saving treatment if I refuse to give my informed consent.
- I hereby release PeaceHealth and my health care providers from any responsibility for any unwanted effects from my refusal of blood products.

Signature of patient		Date	Time
Signature of person authorized to sign for patient – Relationship		Date	Time
Caregiver (witness) signature	3x3	Date	Time
Provider signature	3x3	Date	Time

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