GRAND VIEW HOSPITAL
700 Lawn Avenue
Sellersville, PA 18960

Patient Name: _____

Patient Birthdate: _____

OR Affix Patient Label

PHYSICIAN'S ORDERS
BLOOD PRODUCTS

CHECK ALL ORDERS THAT APPLY.

Diagnosis: _____ **Code:** _____

Transfusion Medication:

- ☐ Diphenhydramine (Benadryl) 25 mg prior to transfusion ☐PO ☐IV
- ☐ Diphenhydramine (Benadryl) 50 mg prior to transfusion ☐PO ☐IV
- ☐ Acetaminophen (Tylenol) 650 mg po x 1 prior to transfusion of PRBCs
- ☐ Furosemide (Lasix) 20 mg ☐PO ☐IV
- ☐ Furosemide (Lasix) 40 mg ☐PO ☐IV
  - ☐ Between units ☐ After transfusion
- ☐ Other: _____

Packed RBCs

☐ Type and Crossmatch for _____ units
PACKED RED BLOOD CELLS (PRBCs)

Special Requirement: ☐ Irradiated ☐ CMV Negative ☐ Autologous

☐ Transfuse _____ units @ _____ hrs/unit

Check Indication for Treatment:

- ☐ Hgb less than 8 g/dl or Hct less than 24%
- ☐ Hgb less than 10 g/dl with ischemic cardiac disease
- ☐ Symptomatic anemia (i.e. SOB, chest pain, tachycardia, fatigue, dizziness
- ☐ Ongoing or anticipated blood loss greater than 500 ml in a 24-hour period
- ☐ Other: _____

☐ Transfuse _____ units **SINGLE DONOR PLATELETS**
(1 unit = 6 random donor units)

Special Requirement: ☐ Irradiated ☐ CMV Negative ☐ HLA

Check Indication for Treatment:

- ☐ Platelet count less than 10,000
- ☐ Platelet count less than 50,000 and active bleeding, surgery, or coagulopathy
- ☐ Platelet count less than 100,000 with evidence of bleeding due to platelet dysfunction
- ☐ Non-functioning platelets due to anti-platelet therapy
- ☐ Medication-induced thrombocytopenia
- ☐ Other: _____

☐ Transfuse _____ units **FRESH FROZEN PLASMA (FFP)**

Check Indication for Treatment:

- ☐ INR greater than 1.4
- ☐ PTT greater than 55 seconds
- ☐ Treatment of coagulation disorders
- ☐ Other: _____

☐ Transfuse _____ units **CRYOPRECIPITATED AHF**

Check Indication for Treatment:

- ☐ Hypofibrinogenia (Fibrinogin less than 115 mg/dl)
  - ☐ Hemophilia A ☐ Von Willebrand's Disease
- ☐ Other: _____

Rh IMMUNE GLOBULIN 300 mcg

Blood Type _____

Gestational Age (weeks) _____

Gestational Size _____

Other: _____

_____

_____

☐ **PATIENT CONSENT OBTAINED - SEE PROGRESS NOTE**

☐ **PATIENT CONSENT OBTAINED - BLOOD CONSENT FORM COMPLETED**

☐ **PATIENT CONSENT OBTAINED PREVIOUSLY** _____ **(Date)**

Physician Signature / #: _____ **Date** _____ **Time** _____

SCANNED: Date _____ **Time** _____ **Initial** _____