Anticipated Start Date: __________ Patient to follow up with provider on date: __________

***This plan will expire after 365 days, unless otherwise specified below***

Orders expire: _____________________

Weight: __________ kg  Height: __________ cm

Allergies: __________________________________________

Diagnosis: ___________________________  Diagnosis Code: ________________

GUIDELINES FOR PRESCRIBING:

1. Send FACE SHEET, INSURANCE CARD, current medication/allergy list, and most recent provider chart or progress note
2. All blood products are leukoreduced
3. Patient has been consented for transfusion and documentation in medical record. Consent valid for 365 days from date signed.

LABS TO BE DRAWN:

- [ ] CBC with differential, STAT, every _____(visit)(days)(weeks)(months) **Circle one**
- [ ] PREPARE (Type and Screen), STAT, ONCE
- [ ] BBH (Blood Bank Hold), Routine, ONCE
- [ ] Labs already drawn. Date: __________
- [ ] Other: __________________________________________

NURSING ORDERS:

1. Vital signs, every visit: routine vital signs
2. **TREATMENT PARAMETERS (Attention Providers: please assign appropriate parameters)**
   a. Blood Transfusion: For hematocrit less than or equal to _____ %, transfuse _____ units of packed red blood cells over ______ hours each (infusion rate per Legacy Policy, if not specified)
   b. Blood Transfusion: for hemoglobin less than or equal to ______ g/dL, transfuse _____ units of packed red blood cells over ______ hours each (infusion rate per Legacy Policy, if not specified)
   c. Platelet Transfusion: For platelet count less than or equal to ______, transfuse _____ units pheresis platelet product.

3. Nursing communication order, every visit: Titrate per Legacy protocol 915.4282
4. Nursing communication order, every visit: Manage line per LH policy 904.4007 IV Catheter Insertion (Peripheral) and LH 904.4004 IV Access: Central Catheters
5. Nursing communication orders, every visit: Manage hypersensitivity reactions per LH 906.6606
SPECIAL NEEDS (May select more than one)

- CMV Seronegative
- Irradiated
- Direct Donor
- Washed
- Phenotype Matched (rarely indicated)
- Other: ________________________________________________________

PRE-MEDICATIONS: (Administer 30 minutes prior to infusion)

- acetaminophen, PO, ONCE PRN for infusion tolerance, every visit
  - 325 mg
  - 650 mg
  - Other __________________________________________________________

- diphenhydramine PO, ONCE PRN for infusion tolerance, every visit
  - 25 mg
  - 50 mg

- cetirizine PO, ONCE PRN for infusion tolerance, every visit
  (Choose as alternative to diphenhydramine if needed)
  - 10 mg

- Other: __________________________________________________________
  (dexamethasone, methylprednisolone, hydrocortisone, famotidine)
BLOOD PRODUCT(S):

☐ Packed Red Blood Cells
  • Amount: _________ Units
  • Interval
    □ Once
    □ Every _________ days for ______ treatments. Begin on date: ____________________

☐ Pheresis Platelets
  • Matched:
    □ HLA Matched
    □ Cross-matched
  • Amount: _________ Units
  • Interval
    □ Once
    □ Every _________ days for ______ treatments. Begin on date: ____________________

☐ Frozen Plasma
  • Amount: _________ Units
  • Interval
    □ Once
    □ Every _________ days for ______ treatments. Begin on date: ____________________

☐ Cryoprecipitate Pool
  • Amount: _________ pools (NOTE: 1 pool = 5 units. Usual adult dose = 2 pools)
  • Interval
    □ Once
    □ Every _________ days for ______ treatments. Begin on date: ____________________

AS NEEDED MEDICATIONS:

☐ furosemide __________ mg IV, every visit (after the first unit of blood product)
### Legacy Day Treatment Unit Provider’s Orders

**Adult Ambulatory Infusion Order**

**BLOOD TRANSFUSION ORDER**

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date of Birth:</th>
<th>Med. Rec. No:</th>
</tr>
</thead>
</table>

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**ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE**

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Please check the appropriate box for the patient’s preferred clinic location:

- [ ] **Legacy Salmon Creek Day Treatment Unit**
  
  Legacy Salmon Creek Medical Center
  
  2121 NE 139th Street, Suite 110
  
  Vancouver, WA 98686
  
  Phone number: 360-487-1750
  
  Fax number: 360-487-5773

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**Provider signature:** ________________________________  **Date/Time:** ________________________________

**Printed Name:** ________________________________  **Phone:** ______________  **Fax:** ______________

**Organization/Department:** ______________________________________________________