## Legacy Day Treatment Unit Provider’s Orders

### Adult Ambulatory Infusion Order

**BLOOD TRANSFUSION ORDER**

**Patient Name:**

**Date of Birth:**

**Med. Rec. No:**

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

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**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:** _____________

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**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.

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**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: ___________________________________________________________

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**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

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*Last updated 4/22/20*
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)
BLOOD TRANSFUSION ORDER

Patient Name: 
Date of Birth: 
Med. Rec. No: 

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

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

☐ Legacy Silverton STEPS Clinic
   Legacy Silverton Medical Center
   342 Fairview Street
   Silverton, OR 97381
   Phone number: 503-873-1670
   Fax number: 503-874-2483

Provider signature: ___________________________   Date/Time: ___________________________
Printed Name: ___________________________   Phone: ___________   Fax: ___________
Organization/Department: ___________________________