

Blood and Blood Components Order Set

Inclusion criteria: Inpatient and outpatients requiring blood products based on clinical lab findings and/or physician judgment.

Exclusion criteria: Any emergent hemorrhagic event that necessitates uncrossmatched blood and peri-operative patients.

= Optional Order • = Routine Order (Cross out and initial **BULLETED ORDERS** that do not apply.)

ORDERS			
Date: _____		Time: _____	
Patient Name: _____		Diagnosis Code: (ICD-10) _____	
Allergies: _____		Date of Birth: _____	
Weight: _____ (kg)			
TRANSFUSION RELATED LABS & MEDICATIONS	Pre-transfusion Medications/Labs:	<input checked="" type="checkbox"/> Obtain CBC as indicated per HH guidelines <input type="checkbox"/> Diphenhydramine (Benadryl) 25 mg PO <input type="checkbox"/> Acetaminophen (Tylenol) 325 - 650 mg PO <input type="checkbox"/> Other:	
	Between Units Medications:	<input type="checkbox"/> Furosemide (Lasix) _____ mg IV between 1 st and 2 nd units <input type="checkbox"/> Furosemide (Lasix) _____ mg PO <input type="checkbox"/> Furosemide (Lasix) _____ mg IV after 2 nd unit <input type="checkbox"/> Other:	
	Post-transfusion Labs:	<input type="checkbox"/> Hgb in: _____ <input type="checkbox"/> Platelet Count in: _____ <input type="checkbox"/> Hct in: _____ <input type="checkbox"/> CBC in: _____ <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Order transfusion reaction. Notify provider suspected reaction.
RED BLOOD CELLS	<input type="checkbox"/> Type and Crossmatch _____ Unit(s) <input type="checkbox"/> Transfuse _____ unit(s) *For patients with cold agglutinins, use a blood warmer and notify physician of presence of cold agglutinins. Pre-transfusion hgb: _____ Date resulted: _____ Indications: <input type="checkbox"/> Actively bleeding patient with hgb less than 10 <input type="checkbox"/> Chronic kidney disease/hemodialysis patient with hgb less than 11 <input type="checkbox"/> Non-actively bleeding, stable patient with hgb less than 8 <input type="checkbox"/> Patients 65 years or older undergoing major surgery with hgb less than 13 <input type="checkbox"/> Patient symptomatic with hgb greater than 8		SPECIAL ORDERS
			<input type="checkbox"/> Irradiated <input type="checkbox"/> Other: ★ Diagnosis & ICD-10 Code: Anemia, secondary to:
PLATELETS	<input type="checkbox"/> Transfuse (= 6 Platelet Concentrates) 1 Platelet Pheresis ★ Diagnosis & ICD-10 Code: Thrombocytopenia, secondary to: <input type="checkbox"/> Transfuse (= 12 Platelet Concentrate) 2 Platelet Pheresis		SPECIAL ORDERS
	Indications: <input type="checkbox"/> Platelet count less than 20,000/ul <input type="checkbox"/> Platelet count less than 50,000/ul and scheduled for minor surgery/biopsy <input type="checkbox"/> Platelet count less than 50,000/ul and actively bleeding <input type="checkbox"/> Platelet count less than 100,000/ul and scheduled for major surgery. <input type="checkbox"/> Other:		<input type="checkbox"/> Irradiated <input type="checkbox"/> Other:
FROZEN PLASMA	<input type="checkbox"/> Transfuse _____ unit(s) Frozen Plasma ★ Diagnosis & ICD-10 Code: Coagulopathy secondary to:		
	Indications: <input type="checkbox"/> INR greater than 1.8 <input type="checkbox"/> Urgent reversal of Warfarin (Coumadin) <input type="checkbox"/> aPTT greater than 60 seconds <input type="checkbox"/> Other:		
CRYOPRECIPITATE	<input type="checkbox"/> Transfuse 5 units Cryoprecipitate ★ Diagnosis & ICD-10 Code:		
	Indications: <input type="checkbox"/> Fibrinogen less than 50 mg/dl; patient stable <input type="checkbox"/> Fibrinogen less than 100 mg/dl; acute hemorrhage/invasive procedure		

Physician Signature: _____

Date: _____

Physician Name and Credentials (please print): _____

Time: _____

Office Phone: _____ Office Fax: _____

