

 <p>LEGACY HEALTH</p>	<p>Legacy Day Treatment Unit Provider's Orders</p> <p>Adult Ambulatory Infusion Order BLOOD TRANSFUSION ORDER</p>	<p>Patient Name: _____</p> <p>Date of Birth: _____</p> <p>Med. Rec. No: _____</p>
<p>ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE</p>		

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



**Legacy Day Treatment Unit
Provider's Orders**

Adult Ambulatory Infusion Order
**BLOOD TRANSFUSION
ORDER**

Patient Name:

Date of Birth:

Med. Rec. No:

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

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)



**Legacy Day Treatment Unit
Provider's Orders**

Adult Ambulatory Infusion Order
BLOOD TRANSFUSION
ORDER

Patient Name:

Date of Birth:

Med. Rec. No:

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

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**

Patient Name:

Date of Birth:

Med. Rec. No:

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

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

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax:** _____

Organization/Department: _____