Sipe Infusion Center
Blood Product Transfusion Orders

Today's Date: _____ **Requested Transfusion Date:** _____

Patient Name: _____ **Date of Birth:** _____

Ordering Clinician (PLEASE PRINT): _____ **MD / DO / NP / PA**

Phone #: _____ **Fax Number:** _____

Diagnosis: _____ **ICD-10 Code:** _____

SPECIAL PRODUCT NEEDS

☐ Leukocyte Reduction Filter
☐ Hemoglobin S Negative
☐ Irradiated (Reason) _____
☐ Other _____

PREMEDICATIONS (prior to transfusion)		**INTERIM & POST**
☐ *No Pre Medications Required*	☐ Famotidine _____mg X 1	Between 1st & 2nd Unit
☐ Acetaminophen _____mg PO X 1	☐ PO ☐ IV	☐ Furosemide _____mg
☐ Diphenhydramine _____ mg X 1	☐ Furosemide _____ mg X 1	☐ PO ☐ IV
☐ PO ☐ IV	☐ PO ☐ IV	Post Transfusion
	☐ Other: _____	☐ Furosemide _____mg
		☐ PO ☐ IV

TRANSFUSE THE FOLLOWING INDICATED PRODUCTS:

Date of Type & Screen: _____ *Drawn at (Facility):* _____

PACKED RED BLOOD CELLS: Hemoglobin Result: _____mg/dL Date:_____

ORDER: ☐ Transfuse _____# Unit(s) Packed Red Blood Cells

RATE: Infuse each unit over: ☐ 120 mL/hour ☐ 180 mL/hour ☐ 240 mL/hour
☐ 1 mL/Kg/hour for patients at risk for fluid overload ☐ Emergent - as quickly as possible

PLATELETS: Platelet Count Result: _____K/uL Date:_____

ORDER: ☐ Transfuse 1 Unit Single Donor Platelets ☐ Transfuse 1 Unit HLA-Matched Platelets

RATE: Infuse each unit over: ☐ 300 mL/hour ☐ 1 mL/Kg/hour for patients at risk for fluid overload
☐ Emergent - as quickly as possible

FRESH FROZEN PLASMA: INR Result: _____ Date:_____

ORDER: ☐ Transfuse _____# Units Fresh Frozen Plasma (FFP)

RATE: Infuse each unit over: ☐ 300 mL/hour ☐ 1 mL/Kg/hour for patients at risk for fluid overload
☐ Emergent - as quickly as possible

OTHER SPECIAL INSTRUCTIONS:

FAX COMPLETED FORM, PATIENT DEMOGRAPHIC FORM, AND CONSENT FORM TO 412-942-3559

Physician Signature:_____ Date: _____ Time: _____