

University of Michigan Health-Sparrow Infusion Services

PHYSICIAN ORDER FOR RED BLOOD CELL TRANSFUSION

Name: _____ D.O.B.: _____ MRN# _____

Room# _____

☐ For Outpatient Infusion on (date): _____

☐ Herbert-Herman Cancer Center ☐ Sparrow Carson ☐ Sparrow Clinton ☐ Sparrow Eaton ☐ Sparrow Ionia

• The minimal effective dose of all blood products should be used. One unit of packed red cells in an adult will increase hematocrit by 3% and hemoglobin by 1 G/dl (8 ml/kg pediatric) **SINGLE UNIT** transfusion of packed red cells is often effective.

☐ **PACKED RED BLOOD CELLS:** Transfuse: _____ Units

☐ Infuse over 1.5 to 3.5 hours OR ☐ Rapidly Infuse - Other rate: _____

SPECIAL NEEDS: Check each box below that applies:

☐ Irradiated ☐ Sickle Cell Negative ☐ CMV Negative ☐ Donor Directed ☐ Autologous

Most recent hemoglobin _____ G/dl or Hematocrit _____ % On (Date): _____ Time: _____

INDICATIONS: MUST CHECK AT LEAST ONE BOX BELOW. NOTE: These indications will be tracked and may be peer reviewed.

☐ Hematocrit less than or equal to 21% or hemoglobin less than or equal to 7 G/dl

☐ Hct < or = to 24% or hemoglobin < or = to 8 G/dl in a patient with CAD & unstable angina/MI/cardiogenic shock

☐ Rapid blood loss > 30-40% of EBV not responding to volume resuscitation, or with ongoing blood loss

☐ Normovolemic, evidence of need for increased oxygen carrying capacity indicated by: (must specify in comments)

☐ Tachycardia, hypotension not corrected by adequate volume replacement alone

☐ PVO₂ < 25 torr, extraction ratio > 50%, VO₂ < 50% of baseline

☐ Other: (must specify in comments)

☐ Radiation or Chemotherapy for (specify) _____

☐ **UNCROSSMATCHED (Emergency Release) Transfuse:** _____ **Units PRBC. Physician must sign below for Uncrossmatched Blood:** I accept the responsibility for and release Blood Bank personnel of the responsibility for any adverse patient reaction resulting from this transfusion. I understand that additional testing will be performed as soon as possible and I will be notified of any significant problems discovered in such testing.

Doctor (Print): _____ Reg. No. _____ Date: _____ Time: _____

Doctor (Signature): _____

FAX COMPLETED ORDER FORM TO:

IFC/MOC Herbert-Herman Cancer Center: (517) 364-8448

IFC/MOC UM Health-Sparrow Carson: (989) 584-0130

IFC/MOC UM Health-Sparrow Clinton: (989) 227-3388

IFC/MOC UM Health-Sparrow Eaton: (517) 541-5821

IFC/MOC UM Health-Sparrow Ionia: (616) 523-1497



UNIVERSITY OF MICHIGAN
HEALTH-SPARROW
MICHIGAN MEDICINE

Faxed by (initials) _____

Date: _____ Time: _____

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INDICATIONS: CHECK ALL THAT APPLY, at least one indication must be checked for each product ordered. *NOTE: These indications will be tracked and may be peer reviewed.*

☐ **FRESH FROZEN PLASMA:** Transfuse: _____ Units

Most recent coagulation studies: PT _____ INR _____ APTT _____ Fibrinogen _____ On (Date): _____ Time: _____

INDICATIONS: MUST CHECK AT LEAST ONE BOX BELOW

☐ Abnormal coagulation studies and significant hemorrhage

☐ Other Indication: (specify) _____

☐ **PLATELETS:** Transfuse: _____ Single donor Pheresis Units

Most recent platelet count _____ cc3 on (Date): _____ Time: _____

A single unit of platelets will increase the platelet count by 30,000-50,000/cc3.

SPECIAL NEEDS: Check each box below that applies

☐ Irradiated ☐ CMV Negative ☐ HLA Matched

INDICATIONS: MUST CHECK AT LEAST ONE BOX BELOW

☐ Platelet count less than or equal to 10,000/cc3 prophylactically in a patient with failure in platelet production

☐ Platelet count less than or equal to 20,000/cc3 and signs of hemorrhagic diathesis

☐ Platelet count less than or equal to 50,000/cc3 in a patient with Active hemorrhage

☐ Platelet count less than or equal to 50,000/cc3 in a patient with surgical procedure

☐ Platelet dysfunction documented by: (specify) _____

☐ Other Indication: (specify) _____

☐ **CRYOPRECIPITATE:** Transfuse: _____ Units

Most recent coagulation studies: PT _____ INR _____ APTT _____ Fibrinogen _____ On (Date): _____ Time: _____

INDICATIONS: MUST CHECK AT LEAST ONE BOX BELOW

☐ Fibrinogen less than 100 mg/dl

☐ von Willebrand's Disease

☐ Fibrinogen less than or equal to 150 mg/dl with active hemorrhage

Doctor (Print): _____ Reg. No. _____ Date: _____ Time: _____

Doctor (Signature): _____

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