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.

☑ By checking this box I confirm the patient/surrogate decision-maker has been informed of the details of the blood and/or blood parts ordered, including the risks, benefits, and alternatives, and has consented to the ordered transfusion.

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: _____

University of Michigan Health-Sparrow Infusion Services
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Name: _____ D.O.B.: _____ MRN# _____
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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/di
□ von Willebrand's Disease
□ Fibrinogen less than or equal to 150 mg/di with active hemorrhage

☑ By checking this box I confirm the patient/surrogate decision-maker has been informed of the details of the blood and/or blood parts ordered, including the risks, benefits, and alternatives, and has consented to the ordered transfusion.

Doctor (Print): _____Reg. No. _____Date: _____Time: _____

Doctor (Signature): _____

FAX COMPLETED ORDER FORM TO:

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MICHIGAN MEDICINE

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Faxed by (initials) _____
Date: _____Time: _____