UNIVERSITY of MARYLAND MEDICAL CENTER
KAUFMAN INFUSION CENTER

Provider Orders for:

Transfusion Orders

Patient Name: ___________________
DOB: __________________

☐ = ***must*** **check off to order / ☑ *automatically* initiated unless crossed out**

DATE: ___________ **TIME:** ___________

Patient to report for **Pre-Transfusion Testing** **the day before** the Transfusion: Date: _____________ Time: _______

Patient to report to **Outpatient Registration** for Transfusion: Date: _____________ Time: _______

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Diagnosis: ____ **ICD Code:**_____________________

Transfusion History (past 3 months): ____
(blood product, where, when)

Lab Results: (*Office to complete if tests done)* within one week

Date Obtained**:**___________ HBG_____ HCT_____ Platelets_____ PT_____ aPTT_____

Other___________________

IV Line Patency Maintenance:

☑ NS IV 250 mL at 30 mL/hr during infusion
☑ Flush central line with 5 mL heparin 100 units/mL IV

Transfusion Product and Duration Orders:

Place checkmark in box to order blood product(s) AND a checkmark or "x" in one of the duration columns for each product ordered.

Transfusion Product	Type/Crossmatch & Transfuse (# Units)	Transfusion Duration for EACH unit						
		15 min	30 min	45 min	1 hr	2 hrs	3 hrs	Other Duration (*specify)*
☐ **Packed Cells**	________units							________ (Do NOT exceed 4 hrs)
☐ **Plasma**	________units							__________
☐ **Platelets**	________units							__________
☐ **Cryoprecipitates**	________units							__________
☐ **Other Product:** __________________	________units							__________

Transfusion Consent form is current (within past 6 months) and complete? ☐Yes ☐No **Date signed**_________

☑ **Diet**: ____

PRE-Medications:

☐ diphenhydrAMINE (Benadryl) ☐ 25 mg **or** ☐ 50 mg ☐ PO **or** ☐ IV times one dose
☐ furosemide (Lasix) 20 mg IV times one dose, after transfusion of 1st unit
☐ acetaminophen 650 mg PO times one dose

☑ If any sign(s) of **reaction** including: •Shortness of breath •Chills •Chest Pain •Elevated Temperature •Urticaria
Stop the transfusion immediately, Notify Provider and Blood Bank

Post Transfusion Labs: ☐ Hematocrit, 1 hour post transfusion ☐ Platelet count, 1 hour post transfusion

☑ May be **discharged** 1 hour after the transfusion is completed if no reaction occurs
☑ Give **transfusion reaction instruction sheet** to patient.
☑ **Special Requirements / Other instructions**: ____

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Authorized Prescriber Signature: ____________________________ Date:______________Time:___________