WENTWORTH-DOUGLASS HOSPITAL
A Mass General Community Hospital

Order Paper

Patient Identification Area

OUTPATIENT BLOOD TRANSFUSION

DIAGNOSIS:_____

Please check to activate each order desired

1. Verify informed consent and obtain copy.

2. MEDICATIONS:

- ❒ Diphenhydramine (Benadryl) _____ mg PO X 1 dose prior to transfusion
- ❒ Diphenhydramine (Benadryl) _____ mg IV X 1 dose prior to transfusion
- ❒ Acetaminophen (Tylenol) 650 mg PO X 1 dose prior to tranfusion
- ❒ Furosemide (Lasix) _____mg IV X 1 dose prior to transfusion
- ❒ Furosemide (Lasix) _____mg IV X 1 dose between units one and two

3. PACKED RED BLOOD CELLS (PRCs)

- **DOCUMENT MOST RECENT HBG_____g/dL OR Hgb_____%**
- **CHECK INDICATION FOR BLOOD TRANSFUSION:**

❒ Hgb < 7.0	❒ Cerebral Ischemic Disease	❒ Otherwise symptomatic
❒ BP < 100 syst, or 20% fall	❒ Bone Marrow Dysfunction	❒ Acute blood loss
❒ Coronary Artery Disease	❒ Hemolysis	❒ Post−op Hgb < 9.9

NO MORE THAN 2 UNITS OF PRCs CAN BE INFUSED PER DAY

❒ **Type and Screen (must be done within 72 hours prior to transfusion)**

❒ **Transfuse _____ Unit(s)**

- Complete tranfusion within 4 hrs per policy PC−17
- Monitor and document vital signs per policy PC−17

Special Requirement * (Requires special order one day in advance):

- ❒ Irradiated*
- ❒ CMV Negative*
- ❒ HgBS Neg*

4. LABS

- ❒ Check H & H 30 minutes after each unit
- ❒ Call provider if H & H greater than 9/27

_____ _____

Physician Signature **Date / Time**

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CONSENT FOR TRANSFUSION OF BLOOD/BLOOD PRODUCTS

Consent Blood Products

Patient Identification Area

TRANSFUSION OF BLOOD OR BLOOD PRODUCTS
(Practitioner must complete in all cases where transfusion is contemplated)

I have discussed the administration of blood or blood products with my physician. I understand the following:

There are potential risks of transfusion, though rare, and that some of these include: transfusion reaction with related fever, itching and rash or hives, or more serious problems such as shock, kidney failure, congestive heart failure and transmission of hepatitis, HIV and/or other infectious agents.

The benefits of transfusion include elevation of the blood level of the product transfused, prevention of low oxygen level and low blood pressure, prevention of bleeding, bruising, hemorrhage into a vital organ, gastrointestinal tract or brain.

The alternatives to transfusion of donor blood products include donating my own blood and receiving my own blood back, or having someone donate blood on my behalf, if either alternative is appropriate in my case.

During our discussion, I had the opportunity to ask questions. I understand that Wentworth−Douglass Hospital is not the supplier of the blood or blood components and does not perform testing on blood for infectious agents. I also understand that the American Red Cross performs testing procedures to prevent the transmission of infection through donated blood, but that these tests do not offer a complete guaranty that the blood and/or blood components, which I may receive, will be completely free from infection.

☐ I consent to the administration of blood or blood products as deemed necessary by my physician.

☐ I consent to serial transfusions for the course of the therapy up to one year. (Valid for one (1) year.)

☐ I consent to receive blood or blood products only as an emergency life saving measure.

Signature of Patient, Parent, Guardian, Health Care Agent or other Representative of Patient	Relationship	Date / Time

Signature of Practitioner

Consent obtained **via telephone** by _____ MD/OD

Witness _____ RN Date / Time _____