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) 541-1668*
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/di

☐ von Willebrand's Disease

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

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Doctor (Print): ___________________________________ Reg. No. __________ Date: ________ Time: _______

Doctor (Signature): ____

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