

Name
MRN
DOB

Patient Identification/Label



VCUHealthTM
Tappahannock Hospital

Outpatient Blood Product Orders

Patient Name: _____ Phone number: _____

Medical Record Number: _____ Date of birth: _____

Weight: _____ kg / lb Height: _____ cm / in Allergies: _____

Diagnosis/ICD 10 Code: _____ Code status: _____

Transfusion indication(s): _____

***Note: Patient will not be scheduled until a copy of recent applicable lab work, H&P, completed VCUHS consent, and insurance cards are received**

Blood Bank Adult

Blood Bank – Type ABORH = Type blood ABSC = Antibody screen XM = Crossmatch
 Type ABORh ABSC XM

Attributes: *at least one option must be marked*

- None Irradiated CMV Negative Sickle Negative

Red Blood Cells

Red Blood Cells Leukoreduced Set Up – Adult – select one of the following:

- 1 Unit(s), Routine Set Up 2 Unit(s), Routine Set Up

Transfusion instructions for nurse – Select one of the following:

- Start when available: Red Blood Cells Leukoreduced, Units, Rate: 150 mL/hr.
 Start when available: Red Blood Cells Leukoreduced, Units, Rate: 225 mL/hr.
 Start when available: Red Blood Cells Leukoreduced, Units, Max Rate: _____ mL/hr.

Platelets

Platelet Pheresis Leukoreduced Set Up – Select one of the following:

- 1 unit 2 units

Transfusion instructions for nurse – Start when available: Platelets Leukoreduced

Fresh Frozen Plasma

FFP Set Up 1 Unit(s), Medical Indication(s): Clotting Factor Deficiencies

Transfusion instructions for nurse: Start when available: Plasma, Units,

Cryoprecipitate

Cryoprecipitate AHF Set Up 1, Product: Medical Indication(s): _____

Transfusion instructions for nurse: Start when available: Cryoprecipitate AHF, Units

Pre-Medication – Select if previous reaction(s) **at least one option must be marked**

None

Pre-transfusion

Post-transfusion

Between 2 units

diphenhydramine

25 mg PO, Pre-Infusion

25 mg IV Push, Pre-Infusion

50 mg PO, Pre-Infusion

50 mg IV Push, Pre-Infusion

acetaminophen

325 mg PO, Pre-Infusion

650 mg PO, Pre-Infusion

methylprednisolone

60 mg IVP, Pre-Infusion

125 mg IVP, Pre-Infusion

furosemide

20 mg IVP, once

40 mg IVP, once

Emergency/Hypersensitivity Meds per VCUHS guidelines

Central line care (if applicable): _____

Post transfusion instructions/orders: _____

Provider Signature: _____ **Printed name:** _____

Date: _____ Time: _____

Provider Emergency Contact Number

Office Phone Number

Office Fax Number



DT-ORDER

Medical Records Copy

H-MR-2065 (11-22)

Tappahannock Blood Bank