niagarahealth
Extraordinary Caring. Every Person. Every Time.

PATIENT INFORMATION

Height _____ cm Weight _____ kg

Allergies _____

Blood Component (Red Blood Cells) Order Set

M	K	O

Orders Processed Date (dd/mm/yyyy) _____
Time (hhmm) _____
By _____
Status _____
Processing Reviewed by _____
Status _____
Faxed by _____

Criteria

- All adult inpatients and emergency adult patients

Note: All **STAT** orders are to be called to your site Transfusion Medicine Laboratory

Not Recommended For

- Massively bleeding or unstable bleeding patients
  Note: This would **ONLY** be patients being transfused for resuscitation due to critical bleeding or the Massive Transfusion Protocol was activated
- Operating Room or Recovery Room patients
- Outpatient Clinic patients

Pre-Transfusion Patient History

☒ Admitting diagnosis _____
☒ Allergies/Sensitivities related to Transfusion _____
☒ Special Transfusion Needs? _____
☒ If Yes, Form 900985 is completed (only once) and sent to the Transfusion Medicine Laboratory
☒ Patient consent completed

Vitals/Monitoring

Vitals

☒ Height and Weight on admission to be documented in Meditech
☒ Temp, HR, RR, BP, SpO_2 – Pre-Transfusion, at 15 minutes, and Post-Transfusion
(Document along with time on Transfusion Product Issue/Nursing Documentation Form)

IV Fluids

IV Fluid

☐ sodium chloride 0.9% at _____ mL/h

Other IV Orders

☐ Saline Lock

Pre-Transfusion Medications

☐ diphenhydr**AMINE** _____ mg ☐ PO **OR** ☐ IV x 1 prior to transfusion if history of allergic reactions
☐ furosemide _____ mg ☐ PO **OR** ☐ IV x 1 prior to transfusion
Note: Consider furosemide in patients at risk for transfusion associated circulatory overload. **It is preferable to give furosemide before the transfusion if the patient is not hypovolemic and is hemodynamically stable**

☐ Telephone Order _____ (Ordering Practitioner, Designation) _____ (Signature) _____ (Date/Time (dd/mm/yyyy hhmm))

If Telephone Order _____ (Ordering Physician) _____ (Date (dd/mm/yyyy)) _____ (Time (hhmm)) ☐ Read Back

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Pre-Transfusion Lab Investigations

☐ Group and Screen (GPS) if required

☒ Group and Screen (GPS) required on each new admission and expires after 96 hours if patient has been transfused or pregnant in the last 3 months

Red Cell Transfusion

Pre-Transfusion Lab Investigations

☒ CBC **prior to each unit**

Hgb = Hemoglobin

Indications and Dosing for Transfusion of Red Cells

Clinical Setting	Recommendation and dose
Hgb less than 60 g/L	Transfusion likely appropriate depending on etiology of anemia, alternative therapies (e.g. iron) may be more appropriate than transfusion. Transfuse 1 unit and recheck patient symptoms and Hgb (CBC) before giving second unit
Hgb 60 – 69 g/L	Consider transfusion. Transfuse 1 unit and recheck patient symptoms and Hgb (CBC) before giving second unit
Hgb 70 – 79 g/L	Consider transfusion in patients with pre-existing cardiovascular disease or evidence of impaired tissue oxygenation. Transfuse 1 unit and recheck patient symptoms and Hgb (CBC) before giving second unit
Hgb 80 – 90 g/L	Likely inappropriate unless evidence of impaired tissue oxygenation
Hgb greater than 90 g/L	Likely inappropriate
Bleeding patient	• Maintain Hgb greater than 70 g/L • If pre-existing cardiovascular disease – maintain Hgb greater than 80 g/L

Note: Do not transfuse based on Hgb value alone. Transfusion of red cells is indicated in the treatment of symptomatic anemia (not fatigue alone)

☒ Pre-transfusion hemoglobin _____ g/L

☒ List patients anemia symptoms _____

☒ Does the patient have cardiovascular disease?
- ☐ No
- ☐ Yes

☒ Does the patient have evidence of impaired tissue oxygenation?
- ☐ No
- ☐ Yes

☐ Telephone Order _____ (Ordering Practitioner, Designation) _____ (Signature) _____ (Date/Time (dd/mm/yyyy hhmm))

If Telephone Order _____ (Ordering Physician) _____ (Date (dd/mm/yyyy)) _____ (Time (hhmm)) ☐ Read Back

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Allergies _____

Blood Component (Red Blood Cells) Order Set	M	K	O
Orders Processed Date (dd/mm/yyyy) _____ Time (hhmm) _____ By _____ Status _____ Processing Reviewed by _____ Status _____ Faxed by	**Red Cell Transfusion Continued…**			
	Administration ☐ **Transfuse 1 unit over _____ hours** **OR** ☐ **Transfuse 2 units, each over _____ hours (Only if hemoglobin is less than or equal to 45 g/L)** (e.g. 1 unit over 2 – 3 hours, maximum 4 hours from issue time from the Transfusion Medicine Laboratory) Note: Consider IV iron instead of red blood cells for patients with stable iron deficiency anemia			
	Post-Transfusion Lab Investigations ☒ CBC Required if an additional unit will be transfused as part of the assessment			
	Further Lab Investigations _____ _____			
	Additional Orders _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____			

☐ Telephone Order _____ Ordering Practitioner, Designation _____ Signature _____ Date/Time (dd/mm/yyyy hhmm)

If Telephone Order _____ Ordering Physician _____ Date (dd/mm/yyyy) _____ Time (hhmm) ☐ Read Back

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