niagarahealth
Extraordinary Caring. Every Person. Every Time.

PATIENT INFORMATION

Height _____ cm Weight _____ kg

Allergies _____

Blood Component (Frozen Plasma) 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

Pre-Transfusion Patient History

☒ Admitting diagnosis _____

☒ Allergies/Sensitivities related to Transfusion _____

☒ 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**

Pre-Transfusion Lab Investigations

☐ Group and Screen (GPS) if required (once per admission)

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

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

Height _____ cm Weight _____ kg

Allergies _____

Blood Component (Frozen Plasma) Order Set

M	K	O

Orders Processed Date (dd/mm/yyyy) _____

Time (hhmm) _____

By _____

Status _____

Processing Reviewed by _____

Status _____

Faxed by _____

Frozen Plasma Transfusion

Pre-Transfusion Lab Investigations

☒ INR **prior to each dose**

Indications and Dosing for Transfusion of Frozen Plasma

Clinical Setting		Recommendation and dose
Diagnosis/Indication	**INR**	
• Significant bleeding • Liver disease with coagulopathy and invasive procedure planned	Greater than 1.7	3 – 4 units
• Microvascular bleeding	1.5 – 2 **OR** unknown and cannot wait for results	3 – 4 units

Dosing is 15 mL/kg = 3 – 4 units (250 mL/unit)

- 3 – 4 units of plasma raises coagulation factor levels by approximately 20% for about 5 hours

*Note: Pre-procedure plasma transfusion is **NOT** required for minor procedures regardless of the INR (e.g. arterial line, intravenous line, PICC line, bone marrow procedure, paracentesis, and thoracentesis)

☒ Pre-transfusion INR _____

☒ Is the patient significantly bleeding?

☐ No

☐ Yes

☒ Does the patient have microvascular bleeding?

☐ No

☐ Yes

☒ Does the patient have liver disease with coagulopathy and has an invasive procedure planned?

☐ No

☐ Yes

Administration

☒ Patient weight (kg) _____

☒ **Transfuse _____ units each over _____**

(e.g. each unit over 30 minutes – 2 hours, maximum 4 hours from issued time from the Transfusion Medicine Laboratory)

☐ 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

niagarahealth
Extraordinary Caring. Every Person. Every Time.

PATIENT INFORMATION

Height _____ cm Weight _____ kg

Allergies _____

Blood Component (Frozen Plasma) Order Set	M	K	O
Orders Processed Date (dd/mm/yyyy) _____ Time (hhmm) _____ By _____ Status _____ Processing Reviewed by _____ Status _____ Faxed by _____	**Frozen Plasma Transfusion Continued…**			
	Post-Transfusion Lab Investigations			
	☒ INR after each dose to reassess the need for additional dosing			
	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

Rev. 08/2018/V1 ORD250

Chart Copy – Do Not Destroy

PatientOrderSets