|  |  |  |
| --- | --- | --- |
| SERVICE | ATTENDING | RESIDENT/ARNP/PA |

|  |  |  |
| --- | --- | --- |
| **INFORMED CONSENT:** | * Signed by patient and/or patient’s representative | * Patient unable to provide consent |

**COMPATIBILITY TESTING & BLOOD COMPONENT(S) REQUEST**

To order blood tests performed by Transfusion Services Lab (TSL) and/or request for blood components, complete (or have RN complete) form **HMC2596**, **Transfusion Services Testing & Blood Product Request**.

* Send Type & Screen if patient does not have a valid sample. (TSL may require additional blood sample to complete testing).

|  |  |
| --- | --- |
| **INDICATION FOR TRANSFUSION:** |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **BLOOD COMPONENT(S) TO TRANSFUSE** | | | | | | | | | | **DATE & TIME TO TRANSFUSE:** | | | |  |
|  | | | | | | |  |  | | |  |  |  | |
| ***Blood Component(s) & Dose to Transfuse*** | | | | | |  | ***Transfuse Each Over***  **(Not to exceed 4 hours)** | | |  |  | ***Other Instructions or Comments***  **(e.g., use fluid warmer)** | |
| * Red Blood Cells |  | * Units | | * mL |  |  | | |  |  |  | |
|  |  |  | | |  |  |  | |
| * Plasma |  | * Units | | * mL |  |  | | |  |  |  | |
|  |  |  | | |  |  |  | |
| * Platelets |  | * Units | | * mL |  |  | | |  |  |  | |
|  |  |  | | |  |  |  | |
| * Cryoprecipitate |  | * Units | | * mL |  |  | | |  |  |  | |
|  |  |  | | |  |  |  | |
|  | | | | | |  |  | | |  |  |  | |
| ***Required Blood Component Attributes (Modifications):*** | | | | | | | | | | | | | |
| * Leukoreduced/CMV Safe | | | * Irradiated | | * Other: | |  | | | | | |
|  | | | | | |  |  | | |  |  |  | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **MEDICATIONS:** (Fax to Pharmacy) | | |  | **ADDITIONAL INSTRUCTIONS:** | | |
| *Pre-Transfusion:* | |  | * Transfuse per Nursing Procedure | | |
|  |  | * Use dedicated IV to transfuse blood | | |
|  |  | * Obtain and document vital signs: | | |
|  |  | * + Within 15-minutes before transfusion | | |
| *Other/PRN:* | |  | * + 15-minutes after transfusion started | | |
|  |  | * + At the end of the transfusion | | |
|  |  | * + As clinically needed | | |
|  |  | * Monitor patient every 30-minutes, and document absence or presence of transfusion reaction | | |
|  |  |
| **LABS:** | | |  | * If transfusion reaction is suspected, stop transfusion, call TSL at 744-3088, and initiate work-up | | |
|  |  |
|  |  | * Other: | |  |
|  |  |  |  | |

**OUTPATIENT SETTING**

* Discontinue IV, review signs and symptoms of transfusion reactions as part of discharge instructions, and discharge patient home after transfusion.