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**Blood Product Order Set Template:   
Red Blood Cells, Platelets, Plasma – Adult**

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| **Allergies/Sensitivities:** | | |
| **Admitting Diagnosis:**  Informed consent completed as per institutional guidelines | | |
| **Date of transfusion:**  Today | Other (DD/MM/YYYY) | STAT (Call blood bank at: XXX-XXX-XXXX) |
| If no existing IV initiate IV 0.9% NaCl to keep vein open  Discontinue peripheral IV after transfusion complete | | |
| **Pre-transfusion medications:**  furosemide mg po prior to transfusion or mg IV prior to transfusion | | |
| **SPECIAL REQUIREMENTS:**  Irradiated product required as per hospital guidelines, specify reason:  Specially matched product required as per hospital guidelines, specify reason: | | |
| **Red Blood Cells**  Pre-transfusion Hb: g/L  Indication:  Low Hb (see hospital guidelines for indications)  Significant bleeding  Symptomatic  Other  Transfuse 1 unit, over hours (e.g. 1 unit over 2-3 hours, maximum 4 hours)  Transfuse units, each over hours  Note: consider IV iron instead of red blood cells for patients with stable iron deficiency anemia | | |
| **Platelets** (1 adult dose = 1 psoralen treated pooled platelet or 1 psoralen treated apheresis unit)  Pre-transfusion platelet count: x 109/L  Indication:  Significant bleeding  Invasive procedure/surgery  Prophylactic (platelet count <10 x 109/L)  Other, specify reason:  Transfuse dose(s), each over hours (e.g. 1 dose over 1-2 hours maximum 4 hours) | | |
| **Plasma** (dose 10-15 mL/kg; each solvent detergent treated plasma unit = 200 mL)  Weight (kg): Pre-transfusion INR:  Indication:  Significant bleeding  invasive procedure/surgery within 6 hours  Reason for coagulopathy:  Liver disease  Other (specify):  Transfuse units/mL, each over minutes/hours (e.g. each unit over 30 minutes to 2 hours, maximum 3.5 hours) | | |
| **Post-transfusion MEDICATIONS**  acetaminophen 500-1000 mg po q4h PRN for temperature greater than 38oC or headache  cetirizine 10 mg PO daily PRN for urticaria, rash or itching | | |
| **Post-transfusion laboratory tests, if indicated:**  (specify) | | |
| Prescriber name (print): Date: Time:  Prescriber signature: Pager #: | | |