

**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/LIndication: [ ]  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 hoursReason 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 #:  |