Columbus Community Hospital
Columbus, Nebraska
**DOCTORS ORDERS**

PLEASE NOTE: Condition of Wound, Removal of Stitches, Consultation, Change in Diagnosis, Complications, Condition on Discharge, Instructions of Patient.

***PLEASE SIGN AND DATE EACH ENTRY***

**PLEASE INDICATE / ALLERGIES**

| NONE | CODEINE | PENICILLIN | SULFA | ASPIRIN | OTHER | HEIGHT |
|---|---|---|---|---|---|---|
| REACTION | | | | | | WEIGHT |

**Authorization is granted to supply medications by non-proprietary name unless checked here** ☐

# PHYSICIANS ORDERS
# (including Medications)

## Blood Transfusion Orders

**2/2024**



**1.** Diagnosis_____

**2.** Treatment Start Date: _____ Date to follow up with provider, if needed: _____

**3.** **If not from CCH physician, send Face Sheet and H&P or most recent chart note.**

**4.** ☐ Urgent (less than 24 hours) ****Requires phone call to infusion clinic****
☐ Semi-Urgent (within 48 hours)
☐ Routine (within 1 week)

**5.** Is patient symptomatic:
☐ Yes, if so describe symptoms: _____
☐ No
☐ Unknown

**6.** Pre- medications:
☐ Acetaminophen 650mg PO once
☐ Diphenhydramine 50mg PO once
☐ Loratadine 10mg PO once **(do not order / give both diphenhydramine and loratadine)**

**7.** ☐PRBC Type and Cross Match for _____ units. **Pre-transfusion Hgb:** _____
☐Irradiated

**8.** ☐ FFP Transfuse _____ units (Type and crossmatch not needed for FFP)

**9.** ☐ Platelets (pheresis unit approximately 250mL) _____units. **Pre-transfusion platelet count:** _____

**10.** ☐ Infuse each unit over _____ hours
☐ Infuse as rapidly as tolerated

**11.** Start IV saline lock or access implanted port per facility protocol.

**12.** 0.9% NaCl 100mL Bag— infuse IV PRN to prime / flush with each unit of PRBC and/or FFP

**13.** ☐ Furosemide 20mg IV once (after the first unit of blood product)
☐ Furosemide 40mg IV once (after the first unit of blood product)

**14.** If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider.
Administer emergency medications per CCH Infusion Center Hypersensitivity Orders
**OR** per the following order: _____

Provider signature: _____ Date/Time: _____

Printed Name: _____ Phone: _____ Fax: _____