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)

Adult Ambulatory Infusion Order **(8/2024)**
Blood Transfusion Orders

Diagnosis Code: ____

Treatment Start Date: _____________ Patient to follow up with provider on date: _________________

This plan will expire after 365 days at which time a new order will need to be placed

GUIDELINES FOR ORDERING

1. Send **FACE SHEET** and **H&P with most recent chart note.**
2. **Providers Required _____ (initials)**: "I have discussed the risks versus benefits of blood products designated below, as well as the risks and alternatives, with the patient/surrogate; they understand and agree to transfusion therapy".
3. CCH Transfusion Blood Consent form must be completed prior to infusion.
4. All patients automatically receive pre-storage leukodepleted, CMV safe red cell and platelet products. If irradiated is needed, please order under special needs section below.
5. Scheduling
   - ☐ Urgent (less than 24 hours) ****Requires phone call to infusion clinic****
   - ☐ Semi-Urgent (within 48 hours)
   - ☐ Routine (within 1 week)
6. Is patient symptomatic:
   - ☐ Yes, if so describe symptoms: ____________________________________
   - ☐ No
   - ☐ Unknown

NURSING ORDERS:

1. VITAL SIGNS – Routine vital signs
2. TREATMENT PARAMETERS – Refer to**: Blood Products Transfusion and Infusion: Adult & Pediatric Policy and INS Standards of Practice**
3. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.
4. Observe patient for signs and symptoms of transfusion reaction for 1-hour post transfusion.

ORDERS /LABS:

☐ PRBC Type and Cross Match for __________units
  Pre-transfusion Hgb_________
  Irradiated – ☐ Yes or ☐ No
☐ FFP Transfuse ________ units. (Type and crossmatch not needed for FFP)
☐ Platelets (pheresis until approximately 250mL) ________ units.
  Pre-transfusion Platelet count: _________

Pick one:
☐ Infuse each unit over ________ hours
☐ Infuse as rapidly as tolerated

(cont.)

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PRE-MEDICATIONS: (Administer 30 minutes prior to infusion)

Note to provider: Please select which medications below, if any, you would like the patient to receive prior to treatment by checking the appropriate box(s)

- ☐ acetaminophen (TYLENOL) tablet, 650 mg, oral, ONCE, every visit
- ☐ diphenhydrAMINE (BENADRYL) capsule, 50 mg, oral, ONCE, every visit.
- ☐ loratadine (CLARITIN) 10 mg tablet, oral, ONCE, every visit **(do not order/give both diphenhydrAMINE and loratadine)**

Medications:

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

☐ Furosemide 20mg IV once (after the first unit of blood product)

☐ Furosemide 40mg IV once (after the first unit of blood product)

HYPERSENSITIVITY:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop **STOP THE INFUSION**.
2. Follow Transfusion Reaction investigation in section F of RIT
3. Obtain vital signs and continue to monitor vitals every 5 minutes.
4. Refer to **Adult Hypersensitivity (HSR) & Allergic Reaction Management** algorithm for assessment guidelines and interventions.
5. Continue to assess as grade of severity may progress.
6. Administer emergency medications as directed on the physician's orders.

HYPERSENSITIVITY MEDICATIONS:

- **Acetaminophen**, **975 mg**, PO, x 1 dose, AS NEEDED for hypersensitivity or infusion reaction.
- **DiphenhydrAMINE inj, 50 mg**, IV, AS NEEDED for hypersensitivity or infusion reaction. May repeat x 1 AS NEEDED per reaction management algorithm.
- **Hydrocortisone Sodium Succinate, 100 mg**, IV, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.
- **Famotidine, 20 mg**, IV, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.
- **Oxygen, 2 Liters/min** per nasal cannula for hypersensitivity or infusion reaction.
- **0.9% Normal Saline, 1000 mL**, IV, 150mL/hr, AS NEEDED for hypersensitivity or infusion reaction.
- **EPINEPHrine HCl (1mg/1mL), 0.3 mg**, IM injection, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.

My NPI number is ____________________________ **(MUST BE COMPLETED TO BE A VALID PRESCRIPTION);** and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: ______________________________ **Date/Time:** _________________

Printed Name: __________________ **Phone:** _____________________**Fax:**_________________