LEGACY HEALTH	**Legacy Day Treatment Unit Provider's Orders** Adult Ambulatory Infusion Order BLOOD TRANSFUSION ORDER	**Patient Name:** **Date of Birth:** **Med. Rec. No**:
ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE		

Anticipated Start Date: _____ Patient to follow up with provider on date: _____
*****This plan will expire after 365 days, unless otherwise specified below*****

Orders expire: _____

Weight: _____kg **Height: _____**cm

Allergies: _____

Diagnosis: _____ Diagnosis Code: _____

GUIDELINES FOR PRESCRIBING:

1. Send **FACE SHEET, INSURANCE CARD, current medication/allergy list, and most recent provider chart or progress note**
2. All blood products are leukoreduced
3. Patient has been consented for transfusion and documentation in medical record. Consent valid for 365 days from date signed.

LABS TO BE DRAWN:

- ☐ CBC with differential, STAT, every _____(visit)(days)(weeks)(months) **Circle one**
- ☐ PREPARE (Type and Screen), STAT, ONCE
- ☐ BBH (Blood Bank Hold), Routine, ONCE
- ☐ Labs already drawn. Date: _____
- ☐ Other: _____

NURSING ORDERS:

1. Vital signs, every visit: routine vital signs
2. TREATMENT PARAMETERS ***(Attention Providers: please assign appropriate parameters)***

    a. Blood Transfusion: For hematocrit less than or equal to _____ %, transfuse _____ units of packed red blood cells over _____ hours each (infusion rate per Legacy Policy, if not specified)

    b. Blood Transfusion: for hemoglobin less than or equal to _____ g/dL, transfuse _____ units of packed red blood cells over _____ hours each (infusion rate per Legacy Policy, if not specified)

    c. Platelet Transfusion: For platelet count less than or equal to _____, transfuse _____ units pheresis platelet product.

3. Nursing communication order, every visit: Titrate per Legacy protocol 915.4282
4. Nursing communication order, every visit: Manage line per LH policy 904.4007 IV Catheter Insertion (Peripheral) and LH 904.4004 IV Access: Central Catheters
5. Nursing communication orders, every visit: Manage hypersensitivity reactions per LH 906.6606

LEGACY HEALTH	**Legacy Day Treatment Unit Provider's Orders** Adult Ambulatory Infusion Order BLOOD TRANSFUSION ORDER	**Patient Name:** **Date of Birth:** **Med. Rec. No**:
ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE		

SPECIAL NEEDS (May select more than one)

- ☐ CMV Seronegative
- ☐ Irradiated
- ☐ Direct Donor
- ☐ Washed
- ☐ Phenotype Matched (rarely indicated)
- ☐ Other: _____

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

- ☐ acetaminophen, PO, ONCE PRN for infusion tolerance, every visit
  - ☐ 325 mg
  - ☐ 650 mg
  - ☐ Other _____
- ☐ diphenhydramine PO, ONCE PRN for infusion tolerance, every visit
  - ☐ 25 mg
  - ☐ 50 mg
- ☐ cetirizine PO, ONCE PRN for infusion tolerance, every visit
  (Choose as alternative to diphenhydramine if needed)
  - ☐ 10 mg
- ☐ Other: _____
  (dexamethasone, methylprednisolone, hydrocortisone, famotidine)

LEGACY HEALTH	**Legacy Day Treatment Unit Provider's Orders** Adult Ambulatory Infusion Order BLOOD TRANSFUSION ORDER	**Patient Name:** **Date of Birth:** **Med. Rec. No**:
ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE		

BLOOD PRODUCT(S):

☐ **Packed Red Blood Cells**

- Amount: _____ Units
- Interval
  - ☐ Once
  - ☐ Every _____ days for _____ treatments. Begin on date: _____

☐ **Pheresis Platelets**

- Matched:
  - ☐ HLA Matched
  - ☐ Cross-matched
- Amount: _____ Units
- Interval
  - ☐ Once
  - ☐ Every _____ days for _____ treatments. Begin on date: _____

☐ **Frozen Plasma**

- Amount: _____ Units
- Interval
  - ☐ Once
  - ☐ Every _____ days for _____ treatments. Begin on date: _____

☐ **Cryoprecipitate Pool**

- Amount: _____ pools (NOTE: 1 pool = 5 units. Usual adult dose = 2 pools)
- Interval
  - ☐ Once
  - ☐ Every _____ days for _____ treatments. Begin on date: _____

AS NEEDED MEDICATIONS:

☐ furosemide _____ mg IV, every visit (after the first unit of blood product)

LEGACY HEALTH	**Legacy Day Treatment Unit Provider's Orders** Adult Ambulatory Infusion Order BLOOD TRANSFUSION ORDER	**Patient Name:** **Date of Birth:** **Med. Rec. No**:
ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE		

Please check the appropriate box for the patient's preferred clinic location:

☐ **Legacy Salmon Creek**
Day Treatment Unit
2121 NE 139th Street, Suite 110
Vancouver, WA 98686
Phone number: 360-487-1750
Fax number: 360-487-5773

☐ **Legacy Silverton STEPS Clinic**
Legacy Silverton Medical Center
342 Fairview Street
Silverton, OR 97381
Phone number: 503-873-1670
Fax number: 503-874-2483

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ Fax: _____

Organization/Department: _____