Northwestern Medicine®

Blood and Blood Product Administration

Order Processing: Fax Form: **Delnor OPIC: Fax (630)208-3467** *Phone (630)208-4446* **CDH PTC: Fax (630) 933-2444** *Phone (630)933-6272*		
Patient Name:	**DOB:**	**MRN** ***(if known)***
Height: cm	**Weight:** kg	
Allergies (list all with reactions):		

Diagnosis and Code REQUIRED for submitting form

Diagnosis:_____Code:_____

Please complete all applicable fields to avoid any delays in scheduling or phone calls for clarification.

☐ Packed Red Blood Cells

Type and Cross for _____ units on _____ (date).

Transfuse _____ units on _____ (date).

Transfuse each unit over_____hours.

Special Needs:

- ☐ Irradiated
- ☐ CMV Negative
- ☐ Other Special Needs _____

☐ Platelets

Type and Cross for _____ units on _____ (date).

Transfuse _____ units on _____ (date).

Transfuse each unit over_____hours.

Special Needs:

- ☐ Irradiated
- ☐ CMV Negative
- ☐ Other Special Needs _____

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Patient Name:	**DOB:**	**MRN** ***(if known)***
Height: cm	**Weight:** kg	
Allergies (list all with reactions):		

Pre-Medications:

- ☐ Acetaminophen (Tylenol) 650 mg, PO, Once, Administer 30 minutes prior to infusion
- ☐ Diphenhydramine 25 mg, PO, Once, May give IV PUSH or PO, Administer prior to infusion
- ☐ Diphenhydramine 50 mg, IVPUSH, Once, May give IV PUSH or PO, Administer prior to infusion
- ☐ Other_____

Medications:

- ☐ Furosemide (Lasix) 20 mg, IV between units.

Nursing Orders

- ☑ Verify informed consent VS per blood administration protocol IV
- ☑ Infusion Nurse to assess the patient's vascular access and initiate orders for line care per department policies and procedures.

IV Fluids:

- ☐ Sodium chloride TKO during infusion.

Hypersensitivity/Anaphylaxis Reaction:

- ☑ Diphenhydramine (Benadryl) 25 mg IV Push PRN Hypersensitivity Reaction or itching. May repeat X 1 if symptoms persist after 30 minutes.
- ☑ Epinephrine (Adrenaline) 0.3 mg, 1:1000, Sub-Q Once PRN Anaphylaxis or Severe Bronchospasm.
- ☑ Hydrocortisone sodium succinate PF (Solu-Cortef) 100 mg IV Push Once PRN Hypersensitivity Reaction, Itching, rash, hives and/or shortness of breath.
- ☑ Oxygen: 2-3 L/min for Hypersensitivity and/or Anaphylaxis reaction.
- ☑ Notify Provider of hypersensitivity/anaphylactic reaction.
- ☑ Sodium Chloride 0.9% IV Bolus 250 mL over 15 minutes Once PRN Hypersensitivity and/or Anaphylaxis reaction.

Provider Name: _____Signature:_____

Date: _____ Time: _____