ArrIVe INFUSION THERAPY

Blood Products Order Form

Place Patient Identifier Barcode Label Here

Patient Name: _____
Date of Birth: _____

Diagnosis Code (ICD-10): _____

Treatment/ Procedure: Transfusion of blood product

Target start date: _____

Actual Weight (Kg): _____

Height _____ (inches) _____ (cm)

Allergies _____

Lab orders:
Type and Screen, CBC
[ ] Other: _____

<u>Physician Orders</u>:
( ) Patient requires irradiated blood products

Transfuse with 1 unit of Packed Red Blood cells as needed for Hgb _____ or _____

Transfuse with 2 units of Packed Red Blood cells as needed for Hgb _____ or _____

Transfuse with_____(enter quantity) pack(s) of Platelets as needed for Plt _____ or _____

Transfuse with_____(enter quantity) unit(s) of Cryoprecipitate as needed for _____

( ) Patient does not require routine pre-medications. Medications for a transfusion reaction will be administered per hospital protocol.

Pre-medicate with the following, 30- 60 minutes prior to the transfusion: ( )
Acetaminophen 650 mg tablet PO

( ) Hydrocortisone Sodium Succinate 100 mg IV Push over 2 minutes
( ) Methylprednisolone Sodium Succinate 125 mg IV Push over 2 minutes

( ) **Select Route of Administration**: Diphenhydramine 50 mg ( )IV push ( ) PO over 1-5 minutes
( ) **Select Route of Administration**: Diphenhydramine 25 mg ( )IV push ( ) PO over 1-5 minutes

( ) Famotidine 20 mg IV push over 2 minutes
( ) Furosemide 40 mg IV push over 2 minutes

(X) Nurse to initiate SJMHS Protocol for Management of Infusion-Related Hypersensitivity Reactions PRN (SJM Outpatient infusion centers- Ann Arbor, Brighton, Canton, Chelsea))

Discharge patient when stable.

Physician Signature: _____ Date: _____

Physician Name: _____ Office Phone: _____
Note: This order is valid for 6 months from date of physician signature.

ArrIVe INFUSION THERAPY

Transfusion/Infusion Worksheet

Phone: (810) 844-7373
Fax: (810) 844-7366
9400 Village Place Blvd. Brighton, MI 48116

Patient Name: Patient DOB: Patient Contact Phone:	MRN #: Insurance Name: Diagnosis (ICD-10 Code):
Ordering Physician Name:	Name and Phone Number of Office Contact:

Please fax this worksheet and the following to the fax number above.

☐ **Recent office note and labs**
☐ **Medication list**
☐ **Standardized order**
☐ **Code Status (if DNAR accompanying paperwork is required)**

Patients are generally notified of their appointment within 3 business days of the request. For questions or concerns regarding this form please call: 810-844-7373.

Patient Performance Status	**Please Select the Following:**
Please check one: ☐ This patient has no limitations for outpatient infusion. **OR** ☐ ECOG 3 – Capable of limited selfcare. Confined to a bed or chair >50% of day. ☐ ECOG 4 – Completely disabled. Confined to bed or chair. Patient is mobile: ☐ Yes ☐ No Patient resides in a medical facility: ☐ Yes ☐ No **For Blood Products, please check one:** ☐ Able to sign consent ☐ Family to be present to provide consent ☐ Consent provided ☐ Hgb above 6.0 – **Hgb Level: _____**	**Special Needs:** ☐ Trach ☐ Feeding Tube ☐ Oxygen ☐ Other: _____ Schedule no later than (specify date):_____ Financial Navigator Name:
Date of request:	Clerk Signature:
Time of request:	Clerk Name (printed):