

**TRANSFUSION ORDER - OUTPATIENT INFUSION CLINIC**

Form 10693 (07/22)

**AUTHORIZATION IS GRANTED TO DISPENSE AND ADMINISTER AN ALTERNATE DRUG PRODUCT ACCEPTABLE TO THE MEDICAL STAFF'S PHARMACY COMMITTEE UNLESS THE DRUG PRODUCT IS SPECIFICALLY CIRCLED.**

<b>Patient Name</b>	<b>DOB</b>	<b>Date</b>
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<b>Diagnosis (Required)</b>	<b>ICD 10 Code(s) (Required)</b>
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**Additional Lab Work**

**Group, Type and Antibody Screen (GTABS)/crossmatch and Transfuse:**

\_\_\_\_\_ units of Packed Red Blood Cells

- Irradiated  
 CMV Negative

**Transfuse:**

\_\_\_\_\_ units of Platelets

- Irradiated  
 CMV Negative  
 Single Donor (HLA)

**Symptom Management:**

- Furosemide (Lasix) 20mg IVP once after first unit transfused (must complete hold parameters below)
  - Hold Furosemide for Systolic Blood Pressure of less than \_\_\_\_\_
  - OR Diastolic Blood Pressure of less than \_\_\_\_\_

**Pretreatment:** (rarely indicated due to universal leukoreduction, unless patient history of known transfusion reaction or other indication)

- Acetaminophen (Tylenol) 650 mg PO once

**Select One:**

- Diphenhydramine (Benadryl) 25 mg PO once  
 Diphenhydramine (Benadryl) 25 mg IV once

**IF PATIENT HAS TRANSFUSION REACTION, FOLLOW TRANSFUSION THERAPY AND TRANSFUSION REACTION POLICIES PER LOCATION.**

**The provider's full signature is to follow the order - Abbreviations for names are not acceptable.**

**Provider Printed Name**

**Provider Signature**

**Date**

**Time**