

**Blood Product Order Set Template:
Red Blood Cells, Platelets, Frozen Plasma – Adult**

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| **Allergies/Sensitivities:**  |
| **Admitting Diagnosis:** [ ]  Informed consent completed as per institutional guidelines  |
| **Date of transfusion:** [ ]  Today | [ ]  Other (DD/MM/YYYY)  | [ ]  STAT (Call blood bank at: XXX-XXX-XXXX) |
| **Pre-transfusion laboratory tests:** [ ]  Group and screen | **Previous transfusion within 3 months:** [ ]  Yes[ ] No |
| **Previous pregnancy within 3 months:** [ ]  Yes [ ] No |
| [ ]  If no existing IV initiate IV 0.9% NaCl to keep vein open [ ]  Discontinue peripheral IV after transfusion complete |
| **Pre-transfusion medications:** [ ]  Furosemide mg po prior to transfusion or mg IV prior to transfusion |
| [ ]  Irradiated product required as per hospital guidelines, specify reason  |
| [ ]  Specially matched product required as per hospital guidelines, specify reason:  |
| **Red Blood Cells** Pre-transfusion Hb: g/L Indication: [ ]  Low Hb [ ]  Significant bleeding [x]  Symptomatic [ ]  Other [ ]  Transfuse 1 unit, over hours (e.g. 1 unit over 2-3 hours, maximum 3.5 hrs.) [ ]  Transfuse units, each over hours Note: consider IV iron instead of red blood cells for patients with stable iron deficiency anemia |
| **Platelets** (1 buffy coat pool or apheresis unit =1 adult dose)Pre-transfusion platelet count: x 109/LIndication: [ ]  Significant bleeding [ ]  Invasive procedure/surgery [ ]  Prophylactic (platelet count <10 x 109/L) [ ]  Other, specify reason: Transfuse dose(s), each over hours (e.g. 1 dose over 1-2 hours maximum 3.5 hours) |
| **Frozen Plasma** (dose 15 mL/kg, = 3-4 units for an adult; each unit 250 mL) Weight (kg): Pre-transfusion INR: Indication: [ ]  Significant bleeding [ ]  invasive procedure/surgery within 6 hoursReason for coagulopathy: [ ]  Liver disease [ ]  Other (specify): Transfuse units, each over (e.g. each unit over 30 minutes to 2 hours, maximum 3.5 hours) |
| **Post-transfusion laboratory tests, if indicated:** [ ]  (specify) |
| Prescriber name (print): Date: Time: Prescriber signature: Pager #:  |