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**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:**  YesNo | |
| **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  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/L  Indication:  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 hours  Reason 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 #: | | | |