LOWER UMPQUA HOSPITAL
OUTPATIENT NURSING DEPARTMENT
600 Ranch Road, Reedsport, OR 97467
Phone: (541) 271-2163 | **Fax:** (541) 271-4058

BLOOD PRODUCTS TRANSFUSION

Patient Name _____ **DOB** _____

Patient Phone # _____ **Patient Weight (Kg)** _____ **Patient Height (cm):** _____

Patient Allergies _____

Provider _____ **NPI#** _____

ICD-10 Code (REQUIRED) _____ **J Code** _____

Primary Diagnosis _____

Secondary Diagnosis _____

Duration (or # of treatments): _____ **Anticipated Infusion Date** _____

**Currently NOT transfusing for Hemoglobin above 7.0 unless symptomatic*

Medical Necessity (Signs/Symptoms/ Reason for Transfusion):_____

NURSING/ ACTIVITIES
Interventions/ Assessments
- ☒ Insert Peripheral IV **or** access port-a-cath
- ☒ Vital Signs: **within 30 minutes prior to transfusion, 15 minutes from start of infusion** and **at end of transfusion'**

MEDICATIONS
- ☒ **0.9% sodium chloride** 250 mL at same rate as blood transfusion PRN until line is clear with each unit of blood product

furosemide (*LASIX*)
Between Units of Blood
- ☐ **furosemide** (*LASIX*) 20 mg IVP **x** 1 dose in between units of blood products
- ☐ **furosemide** (*LASIX*) 40 mg IVP **x** 1 dose in between units of blood products

After Units of Blood
- ☐ **furosemide** (*LASIX*) 20 mg IVP **x** 1 after blood products transfused
- ☐ **furosemide** (*LASIX*) 40 mg IVP **x** 1 after blood products transfused

BLOOD BANK
☐ **Packed Red Blood Cells (PRBC)**
- Packed Red Blood Cells (PRBC) **Quantity:**_____
- Transfuse Packed Red Blood Cells (PRBC) **Quantity:**_____

☐ **Platelets**
- Platelets **Quantity:**_____
- Transfuse Platelets **Quantity:**_____

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Date _____ Time _____ Provider Signature _____

"Statement of Responsibility of Parties: referring Prescriber agrees that in referring patients to Lower Umpqua Hospital Outpatient Nursing Department, the responsibility for the care related to these Outpatient Nursing Therapy Plan orders, as well as administration of any 340B drugs, remains with Lower Umpqua Hospital."

Patient label

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☐ **PORT-A-CATH to be accessed**

☒ **0.9% sodium chloride** flush - 20 mL IV 1 dose PRN upon accessing and de-accessing port (saline before heparin flush)

******Saline before heparin flush******

☒ **heparin** flush 500 units = 5 mL IV **x** 1 dose PRN upon de-accessing port (Saline before Heparin flush)

LABS

Pre-Treatment

- ☐ Hemoglobin
- ☐ Hematocrit
- ☐ CBC with Differential
- ☐ CBC
- ☐ Platelet Count

Post-Treatment

- ☐ Hemoglobin
- ☐ Hematocrit
- ☐ CBC with Differential
- ☐ CBC
- ☐ Platelet Count

DISCHARGE

- ☐ Discharge patient when transfusion is complete.
- ☐ Notify provider with update prior to discharge.

HYPERSENSITIVITY / ALLERGIC REACTION

** *Itching, hives, fever* **

- ☒ **STOP MEDICATION INFUSION if allergic reaction occurs**
- ☒ Establish IV access and infuse **0.9% sodium chloride** 500 mL at 25 mL/hour PRN Hypersensitivity / Allergic Reaction
- ☒ VS Q15 minutes **x** 4 and PRN
- ☒ **acetaminophen** *(TYLENOL)* 650 mg PO Q4HRS PRN Hypersensitivity / Allergic Reaction.
- ☒ **diphenhydramine** *(BENADRYL)* 25 mg IVP PRN Hypersensitivity / Allergic Reaction **x** 1 dose. May repeat **x** 1 ***{Maximum dose = 50 mg}***
- ☒ **NOTIFY** Provider of Hypersensitivity / Allergic Reaction
- ☒ **hydrocortisone** 100 mg IVP PRN Hypersensitivity / Allergic Reactions **x** 1 dose if reaction continues and is not relieved by maximum dose of **diphenhydramine**

ANAPHYLAXIS REACTION

** *Wheezing, Dyspnea, Hypotension, Angioedema, Chest pain, Tongue swelling* **

- ☒ Transfer to Emergency Department (ED) as needed, and **NOTIFY** Provider
- ☒ **epinephrine** 0.3 mg IM PRN anaphylaxis **x** 1 dose

Date _____ Time _____ Provider Signature _____

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