USE PATIENT PLATE

Attachment 3
XIII-12

UNIVERSITY OF CALIFORNIA DAVIS
MEDICAL CENTER,
SACRAMENTO, CALIFORNIA

PHYSICIAN BLOOD ORDER FORM

Current Date_______________ Time _______________ ☐ Informed Consent Completed

COMPONENTS	INDICATIONS (Please ✓ those that apply)	COMPONENT TYPES (Please ✓ & add quantity)
RED BLOOD CELLS	☐ Hgb < 8 g/dL ☐ Acute blood loss >20% blood volume ☐ Symptomatic anemia ☐ Surgery ☐ Other (specify) ________	☐ Adult Packed Cells ___ ☐ Pedi Packed Cells ___ ☐ Autologous Blood ___ ☐ Directed Donor Blood ___ ☐ Whole Blood ___
Platelets	☐ Prophylactic ☐ Plt < 10K production defect ☐ Plt < 20K pediatric ☐ Plt < 50K invasive procedure ☐ Plt < 100K critically ill neonate ☐ Bleeding patients ☐ Plt < 50K w/microvascular bleeding ☐ Plt < 100K w/microvascular bleeding & Cardiopulmonary Bypass (CPB) or ECMO ☐ Qualitative platelet defect (specify) ________ ☐ Other (specify) ☐ ________ ☐ ________	☐ 1/2 Plateletpheresis (Δ 30K) ___ ☐ Plateletpheresis (Δ 60K) ___ ☐ Platelet Concentrates (Δ 10K) ___ ☐ Crossmatched Plateletpheresis* ___ ☐ HLA matched Plateletpheresis* ___ *Must consult with Transfusion Service pathologist ___
Fresh Frozen Plasma	☐ Invasive procedure with INR > 2 ☐ Dilutional coagulopathy ☐ Therapeutic plasma exchange ☐ Warfarin reversal	☐ Jumbo (~600 mL) ___ ☐ Adult (~250 mL) ___ ☐ Pedi (~80 mL) ___
Cryoprecipitate	☐ Diffuse bleeding, fibrinogen < 100 mg/dl ☐ von Willebrand's disease ☐ Factor I or XIII deficiency ☐ Fibrin glue	☐ Cryoprecipitate (pooled of 6) ___ ☐ Cryoprecipitate (fibrin glue) ___
Granulocytes	Bacterial or fungal infection Must consult with Transfusion Service Pathologist	
Rho(D) IMMUNE GLOBULIN	☐ Fetomaternal hemmorhage in an Rh neg female i.e. ectopic pregnancy, abortion, amniocentesis, postpartum, trauma, etc.	RhiG (300 μ g) ___
Special requirements (If these were not ordered at crossmatch, call the blood bank at 4-2870 before ordering them now.)	Check the special requirement and circle the indication for it: ☐ CMV neg: Severely immunosuppressed with 1) Negative CMV titer, or 2) Titer pending ☐ Irradiated: Severely immunosuppressed with 1) BMT/PBSC or 2) Lymphoma/Leukemia or 3) Congenital Immunodeficiency, or 4) Intrauterine/neonatal exchange, or 5) Pediatric solid tumor. ☐ Leukodepleted: 1) To prevent platelet refractorines; or 2) pt. has had 2 or more febrile reactions, 3) CMV prevention. ☐ Other: Please specify ________	

Blood ordered for ☐ Transfusion or ☐ Surgery? Surgery Date _______________

Please transfuse ordered components: ☐ ASAP or ☐ Date/Time _______________

Pre-med: Tylenlol ______ mg PO before transfusion + q ______ hrs prn
For children, dosage is 10 mg/kg

Benadryl ______ mg PO/IV/IM before transfusion + q ______ hrs prn
For children, dosage is 1 mg/kg

Other: _______________

Physician Signature _______________, MD P.I. # ________ Beeper # ________

Fax the form to 4-8636