

HEIGHT: _____ WEIGHT (in Kgs): _____ LACTATING: Y N PREGNANT: Y N

ALLERGIES: _____

PATIENT STATUS

Outpatient Bed Assignment SDC Observation Status Inpatient Admission

Diagnosis: _____

NURSING CARE

- Verify form NUR0306: *Consent for Administration of Blood Products is complete*
- Vital Signs: Pre-transfusion, 15 minutes after transfusion begins x 1, hourly during transfusion, post transfusion, & PRN
- Insert Peripheral IV **or** May access and use: Totally Implanted Device PICC
- Monitor for any signs and symptoms of blood product reaction: Refer to Policy: *Blood Administration*
 - Fever, Chills, Rigors, Flushing, Rash, Hives, Urticaria, Facial Swelling, Distended Neck Veins, N/V, Feeling of Impending Doom, Dyspnea, Respiratory Distress, Crackles, Diminished Breath Sounds, Cyanosis, Cough, Frothy Sputum, Hemoglobinuria, Oliguria, Headache, Malaise, Muscle Aches, Pleuritic Chest/Lumbar/Flank/Thigh Pain, Restlessness, Anxiety, BP Changes (decrease/increase in SBP > 30 mmHg), Rapid thread pulse, CVP Increase
- Stop Transfusion *Immediately*, leave tubing connected, Notify Provider and Lab for any signs/symptoms of blood product reaction

DIETARY

OUTPATIENT ONLY: Regular Renal CCD Cardiac

LABORATORY

- Packed Red Blood Cells** - Type, Crossmatch & Transfuse **1 unit** _____ units
- *Transfusion Indication: Hgb < 7 Hgb < 8 & acute MI Hgb < 8 & Unstable Ischemia Hct < 21
 - Acute Blood Loss > 15% Anticipated Blood Loss > 15% Chronic Transfusion Other Reason
 - Other Reason** - Reason for Transfusion if Transfusion Criteria NOT Met _____
- Apheresis Platelets** - Type and Transfuse _____ unit(s)
- *Transfusion Indication: Platelets < 20,000 **Platelets** < 50,000 & scheduled for OR within 12 hours
 - Platelets > 50,000 & anti-platelet medication (i.e. Plavix) Platelets < 100,000 & neural/eye procedure
 - Excessive Bleeding Other Reason
 - Other Reason** - Reason for Transfusion if Transfusion Criteria NOT Met _____
- Fresh Frozen Plasma (FFP)** - Type and Transfuse _____ unit(s)
- *Transfusion Indication: Prolonged PT Prolonged PTT Progressively increasing PT/PTT from patient normal
 - Coag Factor Deficiency Other Reason
 - Other Reason** - Reason for Transfusion if Transfusion Criteria NOT Met _____
- Cryoprecipitate** - Type and Transfuse _____ unit(s)
- CBC w/o Diff within 2 hours post-transfusion of PRBC Platelets within 18 hours post-transfusion of Apheresis Platelets
- No Post Transfusion CBC; Reason: _____

MEDICATIONS

- Normal Saline 250 mL IV @ 30 mL/hour
- Tylenol 650 mg PO x 1 dose prior to transfusion of 1st unit of blood product
- Benadryl 25 mg PO x 1 dose prior to transfusion of 1st unit of blood product
- Solu-Medrol 125 mg IV x 1 dose prior to transfusion of 1st unit of blood product
- Lasix 10 mg 20 mg 40 mg 60 mg PO x 1 dose following first transfused unit of blood product
- Lasix 10 mg 20 mg 40 mg IV x 1 dose following first transfused unit of blood product
- De-access Totally Implanted Device with NS 10 mL IV x 1 followed by Heparin (100 units/mL) 5 mL IV x 1
- De-access PICC with NS 10 mL IV x 1 followed by Heparin (10 units/mL) 3 mL IV x 1

DISCHARGE

Discharge to Home after transfusion and applicable post transfusion labs are complete. Resume Home Medications.

Printed Name of Provider

Provider Signature

Date/Time



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Jacksonville, NC 28546

Blood Product Form



Rev. 03/25

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**ONslow MEMORIAL HOSPITAL
 CONSENT FOR ADMINISTRATION OF BLOOD/BLOOD PRODUCTS**

1. I understand that Dr. _____ or his/her covering physician has determined I need or may need one or more transfusions of blood or blood products to treat my medical condition or replace blood lost during _____
Name of treatment/procedure. Description in lay & medical terms.
 to be performed at Onslow Memorial Hospital.
2. I understand that physicians other than the operating physicians named above, including residents under the supervision of an operating physician, may be performing important tasks related to my treatment. If applicable, qualified medical practitioners, who are not physicians may perform important tasks associated with my treatment, including the administration of anesthesia. I understand that all individuals involved in my care will perform only those tasks that are within their scope of practice according to state and federal laws, and for which they are credentialed.
3. I understand that although there are expected benefits of this transfusion, there are also risks, including, but not limited to hepatitis, HIV, and bacterial, fungal or parasitic infections. I understand that risks are unusual, but real, even if the blood is carefully screened. I have had a discussion about any circumstances under which my health information must be disclosed or reported under state or federal law.
4. I understand that it is possible to experience a transfusion reaction which may be minor such as a rash or itching or major such as a stroke, kidney failure, shock, coma, or death.
5. I understand there are risks of not having the transfusion. I understand I have the right to have all my questions answered with regard to the risks, benefits, and consequences of this proposed transfusion. I have had a discussion about and have been made aware of the risks, benefits, and side effects related to the alternatives to receiving blood/blood products and the risks related to not receiving blood/blood products.
6. I am aware that there is a directed donor program in North Carolina that I may be able to take advantage of. I realize it takes at least 5-7 working days from point of donation to when it is available for use and my condition may not allow for that delay.
7. I am aware that there is a program in North Carolina that allows a patient to donate ones own blood prior to the need. I realize this process takes at least 5-7 working days from point of donation to when it is available for use.

I do hereby consent to the administration of Blood/Blood Products.

Date	Time	Signature of Patient or Responsible Person
Date	Time	Signature of Witness

I, Dr. _____ have explained the procedure, including the risks, benefits, and alternatives to the above patient or responsible person regarding the planned procedure.

Signature of Physician

Valid until 2400 30 days after signature.

Translator: _____

