Cayuga MEDICAL CENTER
A Member of Cayuga Health

Patient Sticker - Place on Both Copies

Blood Product Order Form

☐ CHECK FOR EMERGENCY TRANSFUSION PROTOCOL (ETP), ENTER INDICATIONS, THEN SIGN BELOW* Indications for Protocol: _____

Red Blood Cells # of units: _____	**Plasma** # of units: _____
☐ Acute blood loss *(>20% vol, 70 mL/kg)*	☐ Active Central Nervous System Bleed
☐ HGB <7	☐ INR >1.7 or PTT >50 *(bleeding or pre-op pt)*
☐ HGB <8 *(symptomatic or cardiac disease)*	Reason for prolonged test: _____
☐ Oncology Patient Hgb: _____	☐ Other: _____
☐ Other: _____	
	See Blood Product Administration Policy for dosing guide
Platelets *(call 4484 to order, not stocked)*	**Cryo** # of units: _____
☐ Active Central Nervous System Bleed	☐ DIC w/bleeding *or vol overload)*
☐ Chronic, stable thrombocytopenia *(<5000)*	☐ Fibrinogen <100 *(bleeding, procedure or vol overload)*
☐ DIC w/bleeding or procedure *(<50,000)*	☐ Other: _____
☐ Neurosurgery *(<100,000)*	
☐ Oncology Patient *(<10,000)*	
☐ Platelet function disorder: _____	
☐ Septic Patient *(<20,000)*	
☐ Other: _____	*See Blood Product Administration Policy for dosing guide*

STANDARD TRANSFUSION RATES:

First 15 minutes: required for all products :60 mL/hr

After 15 minutes: RBCs - 150 mL/hr, Plasma/Platelets/Cryo - 300 mL/hr

ALTERNATE TRANSFUSION RATES *(may be prescribed by provider):*

☐ CHF/Fluid Sensitive Transfusion Rate *(after 15 minutes)* :100 mL/hr

☐ Provider ordered Transfusion Rate *(after 15 minutes)* : _____

ETP* Provider signature indicates patient requires immediate release of blood products and provider takes full responsibility for administration of the products before completion of crossmatch testing.

Ordering Provider (print): _____

Provider Signature: _____ **Date / Time:** _____

Nurse Signature: _____ **Date / Time:** _____