Cayuga HEALTH

☐ Cayuga Medical Center
☐ Schuyler Hospital

Place Patient Sticker Here

-or-

Name: _____

DOB: _____

MRN: _____

Downtime Blood Product Order Form

Notify the Blood Bank at (CMC: 4-4484) (SH: 52719) if units are needed Emergently	
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** *(Only one unit may be ordered at a time)*	☐ **Cryo (Pooled)** # of units: _____
☐ Active Central Nervous System Bleed	☐ DIC w/bleeding
☐ Chronic, stable thrombocytopenia *(<5000)*	☐ Fibrinogen <100 *(bleeding, procedure or vol overload)*
☐ DIC w/bleeding or procedure *(<50,000)*	☐ Other: _____
☐ Neurosurgery *(<100,000)*	*See Blood Product Administration Policy for dosing guide*
☐ Oncology Patient *(<10,000)*	
☐ Platelet function disorder: _____	
☐ Septic Patient *(<20,000)*	
☐ Other: _____	
STANDARD TRANSFUSION RATES:	
First 15 minutes: required for all products - 60 mL/hr	
After 15 minutes: RBCs - 240 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 • Inform the Blood Bank if a split unit is needed	
☐ Provider ordered Transfusion Rate *(after 15 minutes)* - _____	

Ordering Provider (print): _____

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

OR

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

(Verbal order, taken and read back by above signed nurse)

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