OLIVE VIEW - UCLA MEDICAL CENTER

PHYSICIAN'S TRANSFUSION ORDERS

Physicians and Nurses; Use Black Ball Point Pen Only. Press Firmly. Start New Section for Each Set of Orders, X-out unused portion of each section.

DIAGNOSIS: **PRIMARY SERVICE**

☐ **Consent to Blood Transfusion** obtained **Pre-Transfusion:** Hb: _____ Hct: _____ PT/INR: _____ Plts.: _____

ALLERGIES: **Weight:** **Height:** (if applicable)

PREMEDICATIONS: ☐ No Premedication

☐ Diphenhydramine mg. ☐ PO x 1 30 min to 1 hour before transfusion

☐ Acetaminophen mg. ☐ PO ☐ PR x 1 30 min to 1 hour before transfusion

IV Solution: 0.9% Sodium Chloride Rate ml/hr.

TRANSFUSE: ☐ Irradiated

( ) Packed Red Blood Cells: ☐ Units ☐ ml, each unit to run over _____ hours

( ) Plateletpheresis: ☐ Units ☐ ml, each unit to run over _____ hours

( ) Cryoprecipitate: ☐ Units ☐ ml, each unit to run over _____ hours

( ) FFP: ☐ Units ☐ ml, each unit to run over _____ hours

( ) Directed Donor

( ) Other

Date	Time Written	Physician Signature	
Physician's I.D #		Service	
R.N.'s Signature		Date	Time
Fax By			

PATIENT DATA - Imprint or Print Legibly

Name:

MRUN:

Date of Birth:

Ward or Clinic:

Req. Loc. Code:

T-OV1708

FILE IN MEDICAL RECORD

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