Physician Orders PEDIATRIC: LEB Transfusion 4 Months of Age or Greater Plan

LEB Transfusion 4 Months of Age or Greater Plan

Patient Care

☐ Consent Signed For
Procedure: Transfusion of Blood/Blood Products

☐ Nursing Communication
Do not delay transfusion treatment for premedications

☐ Nursing Communication
Post Transfusion: Enter order for Hemoglobin and Hematocrit 4 hours after completion of blood products transfusion. (DEF)*
Post Transfusion: Enter order for Hemoglobin and Hematocrit 6 hours after completion of blood products transfusion.

Medications

☐ +1 Hours acetaminophen
10 mg/kg, Liq, PO, once, Routine, Give prior to transfusion (up to one hour) (DEF)*
Comments: Max Dose = 75 mg/kg/day up to 4g/day

☐ +1 Hours acetaminophen
325 mg, Tab, PO, once, Routine, Give prior to transfusion (up to one hour)
Comments: Max Dose = 75 mg/kg/day up to 4g/day

☐ +1 Hours acetaminophen
10 mg/kg, Supp, PR, once, Routine, Give prior to transfusion (up to one hour)
Comments: Max Dose = 75 mg/kg/day up to 4g/day

☐ +1 Hours diphenhydramINE
1 mg/kg, Elixir, PO, once, Routine, Give prior to transfusion (up to 30 minutes) (DEF)*
Comments: Max dose = 50 mg

☐ +1 Hours diphenhydramINE
25 mg, Cap, PO, once, Routine, Give prior to transfusion (up to 30 minutes)

☐ +1 Hours diphenhydramINE
50 mg, Cap, PO, once, Routine, Give prior to transfusion (up to 30 minutes)

☐ +1 Hours methylPREDNISolone
1 mg/kg, Ped Injectable, IV, once, Routine, Give prior to transfusion (up to 30 minutes) Max dose = 50 mg

☐ +1 Hours methylPREDNISolone
25 mg, Cap, PO, once, Routine, Give prior to transfusion (up to 30 minutes)

☐ +1 Hours methylPREDNISolone
50 mg, Cap, PO, once, Routine, Give prior to transfusion (up to 30 minutes)

☐ +1 Hours methylPREDNISolone
MethylPREDNISolone
1 mg/kg, Ped Injectable, IV, once, Routine, Give prior to transfusion (up to 30 minutes) Max dose = 80 mg

Laboratory

☐ Direct Coombs
Routine, T;N, once, Type: Blood

☐ Indirect Coombs
Routine, T;N, once, Type: Blood

☐ Type and Screen Pediatric
Routine, T;N, Type: Blood

☐ Type and Screen
Routine, T;N, Type: Blood

☐ Type and Crossmatch Pediatric >4 months
Routine, T;N, Type: Blood

☐ Type and Crossmatch PRBC
Routine, T;N, Type: Blood

☐ Transfuse PRBC >4 Months
Routine, T;N

☐ Transfuse PRBC's >4 Months-Pediatric
Routine, T;N

☐ Hold PRBC >4 Months
Routine, T;N
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- Hold PRBC
  - Routine, T;N
- Crossmatch Additional Units-Pediatric
  - Routine, T;N
- Crossmatch Additional Units
  - STAT, T;N
- Crossmatch Units from Type and Screen-Pediatric
  - Routine, T;N
- Crossmatch Units from Type and Screen
  - Routine, T;N
- Blood Product Keep Ahead Order-Pediatric
  - Routine, T;N
- Blood Keep Ahead Order
  - Routine, T;N
- FFP Transfuse-Pediatric
  - Routine, T;N
- Platelet Transfuse-Pediatric
  - Routine, T;N
- Cryoprecipitate Transfuse-Pediatric
  - Routine, T;N
- Cryoreduced Plasma Transfuse-Pediatric
  - Routine, T;N
- Emergency Uncrossmatched Blood-Pediatric
  - Routine, T;N
- Transfuse Granulocytes requires Blood Bank approval (287-6356), (NOTE)*
- Granulocytes Transfuse-Pediatric
  - Routine, T;N, Irradiated

Date _______________ Time _______________ Physician’s Signature _______________ MD Number _______________

*Report Legend:
DEF - This order sentence is the default for the selected order
GOAL - This component is a goal
IND - This component is an indicator
INT - This component is an intervention
IVS - This component is an IV Set
NOTE - This component is a note
Rx - This component is a prescription
SUB - This component is a sub phase, see separate sheet
R-Required order