The Mount Sinai Hospital
One Gustave L. Levy Place
New York, New York 10029

## TRANSFUSION ORDER SHEET

PATIENT NAME
DATE OF BIRTH
MEDICAL RECORD NUMBER
DATE OF SERVICE
LOCATION OF SERVICE

1. ENTER ALL ORDERS OR PROCEDURES
2. URGENT ORDERS MUST BE CALLED TO THE ATTENTION OF THE NURSE
3. TO CHANGE OR DISCONTINUE AN ORDER A COMPLETE NEW ENTRY MUST BE MADE
4. DATE,TIME,PRESCRIBER'S SIGNATURE AND DICTATION MUST FOLLOW EACH SET OF ORDERS

**Fax Completed Orders for NON-ONCOLOGY related transfusions to: 212-876-4776 (Location: Annenberg 3 Area D)**

**Fax Completed Orders for ONCOLOGIC related diagnosis to 212-241-7141: (Location: Ruttenberg Treatment Center)**

Patients Diagnosis: ____________ HGB: ______, HCT: ______, Platelet Count ________. Allergies: ____________

**IN ACCORDANCE WITH THE HOSPITAL FORMULARY SYSTEM CURRENTLY STOCKED DRUGS WILL BE DISPENSED**

| Date Ordered | Time | ORDER<br>Please check or circle all appropriate orders | RN √ | RN Signature DATE/TIME |
|---|---|---|---|---|
| | | 1. Blood Product to be given on __________, __________, 2010.<br>(Month) (Date) | | |
| | | 2. Lab orders:<br>☐ Type and Screen for ________ units of ____________ | | |
| | | 3. Verify that a consent for the administration of blood/blood products has been obtained and is current. | | |
| | | 4. Pre-medicate with:<br>☐ Acetaminophen 650 milligrams P.O.<br>☐ Diphenhydramine 25 mg P.O.<br>☐ Other: ____________ | | |
| | | 5. Additional Medication Order:<br>☐ ____________<br>☐ ____________<br>☐ ____________ | | |
| | | 6. Obtain vital signs pre-transfusion. | | |
| | | 7. Start IV of ________ @ ________ cc/hour | | |
| | | 8. Transfuse ________ Units Packed Red Blood Cells.<br>☐ Irradiated<br>☒ Leukodepleted | | |
| | | 9. Initiate each unit of blood at a rate of 50 milliliters per hour for the first 15 minutes of the transfusion. Record vital signs. If the patient is tolerating the transfusion well, increase the rate to infuse each unit over ________ hour. | | |
| | | 10. Transfuse ________ single donor platelets over ________ minutes.<br>☐ Irradiated<br>☐ Leukodepleted | | |
| | | 11. If any signs or symptoms of a transfusion reaction occur:<br>Stop transfusion Immediately; Notify MD: ________ Pager:# ____<br>☐ Meperedine ________ milligrams intravenously<br>☐ Acetaminophen 650 milligrams P.O.<br>☐ Diphenhydramine ________ milligrams intravenously<br>☐ Hydrocortisone ________ milligrams intravenously | | |
| | | 12. Obtain post-transfusion labs as follows: | | |
| | | 13. Provide post-transfusion discharge instructions. | | |
| | | Prescriber Name: ____________ (Print)<br>Prescriber Signature & Title: ____________ MD /PA / NP<br>Dictation Number: ________ Pager Number: ________ | | |

FORM 1735 (Revised 10/20/10)

**The Mount Sinai Medical Center**
One Gustave L. Levy Place
New York, NY 10029

| | Date |
|---|---|
| | Name |
| MRN -<br>V - | Unit # |
| | Sex/DOB |
| | Physician Service |

# TRANSFUSION CONSENT FORM

1. Physician/Provider________________ has informed ____________________
(Name of Patient or "Me")
that I need or may need a transfusion of blood and/or one of its products in the interest of my own health and proper medical care.

2. The physican/provider above has fully explained to me in a language I understand the nature of the proposed transfusion and has also informed me of the potential benefits and risks or side effects, including potential problems that might arise during recuperation, as well as the likelihood of achieving the proposed goals. I have been informed about reasonable alternatives to the proposed transfusion, the relative benefits and risks or side effects related to such alternatives, as well as the risks of not receiving the transfusion. I have been given the opportunity to ask questions, and all my questions have been answered fully and satisfactorily.

| | | | | |
|---|---|---|---|---|
| **Patient, Relative, or Guardian*** | Print Name | Signature | Date/Time | ( ) Relationship |
| **Signature Witness** | Print Name/Title | Signature | Date/Time | |

I ____________________ hereby certify that I have explained the nature, purpose, benfits, risks of,
(Physician/Provider)
and alternatives to, the proposed procedure/operation, have aoffered to answer any questions and have fully answered all such questions. I believe the patient/relative/guardian fully understands what I have explained and answered. In the event that I was not present when the patient signed the form, I understand that the form is only documentation that the informed consent process took place. I remain responsible for having obtained consent from the patient.

| Print Name | Physican/Provider Signature | Date/Time | Dict # |
|---|---|---|---|

* The signature of the patient must be obtained unless patient is under the age of 18 or incompetent
NOTE: THIS DOCUMENT MUST BE PART OF THE PATIENT'S MEDICAL RECORD