Lewis County Health System

7785 North State Street
Lowville, New York 13367
Phone 315-376-5200
Fax 315-376-5153
www.lcgh.net

CONFIDENTIAL

DATE: _____

PLEASE DELIVER TO: **Lewis County Health System – ASU Department**

FAX #: **315-376-0130**

COMPANY: _____

FROM: _____

NUMBER OF PAGES (INCLUDING COVER SHEET): 4

SUBJECT: **INFUSION REQUEST**

NOTES: _____

Lewis County Health System
Your Health Partner

Cover Sheet

OUTPATIENT SERVICES REQUEST CHECKLIST

What is needed to schedule your patient for treatment at Lewis County General Hospital

Patient Name	DOB	Gender	Patient Phone #

Please attach separate order form for Infusion or procedure (i.e., wound care)

Diagnosis/Indications for treatment:

Please ensure the following are attached:

☐ **Authorization / Insurance approval completed**

Reference # _____ Date _____

Authorization # _____ Date _____ Expiration Date _____

☐ **Patient Demographic Cover Sheet**

☐ **LCGH specific Order Sheet completed in full?**

- ☐ Patient's name
- ☐ Patient's DOB
- ☐ Diagnosis
- ☐ Signed, dated, and timed by ordering physician
- ☐ Allergies

☐ **Consent completed** (for blood products including IVIG)

☐ **H&P or initial treatment and annually thereafter to include (at a minimum) – patient age, diagnosis, problem list, medication list, physical exam, and purpose for drug.**

☐ **Print and fax to LCGH Ambulatory Outpatient Department**

Please make sure **ALL boxes are checked prior to faxing to LCGH ASU
Upon completion, scheduling will be done by LCGH

Provider (or designee) Print Name	Phone #	Fax #

Provider (or designee's) Signature	Date

Fax completed form to: 315-376-0130 / Contact us directly at: 315-376-5233 / Visit us online at: lcgh.net

Lewis County General Hospital
& Residential Health Care Facility
An affiliate of St. Joseph's Health
7785 N. State Street, Lowville, NY 13367
315-376-5200

Consent for Blood / Blood Component Transfusion

Patient Identifiers (2)

Patient _____ Patient # _____

1. I understand that I am to receive a transfusion of a blood component. I understand what a blood transfusion is and the procedure that will be used.
2. The possible risks and consequences associated with the transfusion have been explained to me. I understand that these risks may include bruising, fever and hives; chills, chest pain, hypotension, nauseau, flushing, back pain, generalized bleeding, headache or dizziness during or after transfusion. The risk of transmission of infectious diseases such as Hepatitis (B and C), HIV, CMV (Cytomegalovirus), HTLV 1 / II Infection or Malaria is small but can not be completely eliminated. A small number of people may also react by developing antibodies to the blood. This is called an immune reaction. Other risks include fluid overload, chemical imbalances and breakdown of red blood cells.
3. I understand the alternatives available including medications and types of intravenous fluids also carry a risk of complications and varying degree of success.

   Additional risks and alternatives: _____

   _____
4. I understand that I must remain on the hospital premises under physician supervision for at least 1/2 hour after the transfusion is completed.
5. I understand that I can ask the nurse, transfusion service supervisor or physician any questions I may have about this procedure.
6. I understand that the blood bank has taken the necessary precautions in selecting blood donors and in storing and cross matching blood used for the transfusion. However, no guarantees can be or have been made to me about the outcome of this transfusion or about the fitness or quality of the blood to be used in this procedure.
7. For out patient transfusions, this form once signed is good for 90 days unless revoked by the patient.
8. For in patient transfusions, this form once signed is good for the entire hospitalization unless revoked by the patient.

This procedure has been fully explained to me and I understand the contents of this form.

_____ Date_____ Time:_____
Signature of patient or legal representative

_____
Relationship if signed by other than patient

_____ Date_____ Time:_____
Witness signature

_____ Date_____ Time:_____
Phone Consent Obtained

_____ Date_____ Time:_____
Witness signature (for phone consent)

I certify that I have explained the nature of this procedure and it's associated risks and alternatives to the patient and / or his / her representative.

_____ Date_____ Time:_____
Physician's Signature

Lewis County Health System

DOCTOR'S ORDER SHEET - PHARMACY

Place **patient identification sticker** and/or **two patient identifiers.**

IMMUNE GLOBULIN (IVIG) 10% INFUSION

Ht _____ Wt _____ (kg)

ORDERS GOOD FOR THE YEAR OF 20_____

☐ **ADMIT TO ASU OUTPATIENT**

Diagnosis:

Allergies:

Vital Signs: Every 15 minutes

IV: 0.9% Normal Saline @ 30mL/hr

Regular Diet

PRE-MEDICATIONS: SELECT ALL THAT APPLY

☐ Methylprednisolone 40mg IV x 1 - 30 minutes prior to infusion

☐ Diphenhydramine _____mg PO x 1 - 30 minutes prior to infusion

☐ Diphenhydramine _____mg IV x 1 - 30 minutes prior to infusion

☐ Acetaminophen 650mg PO x 1 - 30 minutes prior to infusion

☐ Other: _____

Medication

Immune Globulin 10%

DOSE: _____

ROUTE: IV

FREQUENCY: _____

IF INFUSION-RELATED REACTION OCCURS (FOR ALL ORDERS):

1. **STOP infusion**
2. **Alert rapid response team (if clinically indicated)**
3. **Increase 0.9% Normal Saline to 999 ml/hr**
4. **Administer PRN medications per infusion reaction medications listed below**
5. **Notify Physician**
6. **Vital signs every 10 minutes**

ADMINISTER INFUSION

☐ Administer at 0.5mL/kg/hr and if no infusion reaction may increase by 0.5mL/kg/hr every 30 minutes until complete

OR

☐ Administer infusion at _____ until completed

INFUSION REACTION MEDICATIONS

Follow reaction infusion protocol unless otherwise indicated (FOR ALL ORDERS):

☐ Albuterol 2.5mg via nebulizer x1 as needed for shortness of breath/wheezing

☐ Diphenhydramine 25mg IV every 15 mnutes x2 as needed for urticaria, pruritis, shortness of breath

☐ Other:

NURSING ORDERS

- Obtain blood consent / confirm that it has been signed
- Monitor patient for 60 minutes after infusion is complete
- Temperature recorded every hour
- Access port-a-cath, flush with 0.9% NS 10mL post infusion, followed by Heparin 500 units (if applicable)
- Use PICC line, flush with NS 10mL post infusion with 0.9% NS (if applicable)
- Discharge when criteria met

Nurse signature _____ Date: _____ Time: _____

Qualified Medical Provider Name (Print) : _____ NPI#: _____

Signature: _____ **Date:** _____

Phone Number: _____ **Time:** _____

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