



# Lewis County Health System

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Phone 315-376-5200  
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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): **5**

SUBJECT: **INFUSION REQUEST**

NOTES: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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## OUTPATIENT SERVICES REQUEST CHECKLIST

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

Patient Name	DOB	Gender	Patient Phone #
<b>Please attach separate order form for Infusion or procedure (i.e., wound care)</b>			
<b>Diagnosis/Indications for treatment:</b>			

**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



# Consent for Blood / Blood Component Transfusion

7785 N. State Street, Lowville, NY 13367  
315-376-5200

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, nausea, 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.**

\_\_\_\_\_  
Signature of patient or legal representative Date \_\_\_\_\_ Time: \_\_\_\_\_

\_\_\_\_\_  
Relationship if signed by other than patient

\_\_\_\_\_  
Witness signature Date \_\_\_\_\_ Time: \_\_\_\_\_

\_\_\_\_\_  
Phone Consent Obtained Date \_\_\_\_\_ Time: \_\_\_\_\_

\_\_\_\_\_  
Witness signature (for phone consent) Date \_\_\_\_\_ Time: \_\_\_\_\_

**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.**

\_\_\_\_\_  
Physician's Signature Date \_\_\_\_\_ Time: \_\_\_\_\_





**Packed Cell Order Form**

Patient Identifiers (2) \_\_\_\_\_

1. Patient Name \_\_\_\_\_

Medical Record # \_\_\_\_\_

Room # \_\_\_\_\_

Diagnosis \_\_\_\_\_

2. Order Priority: Routine \_\_\_Urgent\_\_\_Stat \_\_\_ Date of Transfusion or Surgery \_\_\_\_\_

**3. COMPONENT DESIRED # REQUIRED SPECIAL NEEDS: N / Y (If Y, select below)**

Leukoreduced Packed Cells \_\_\_\_\_

\_\_\_ Irradiated

\_\_\_ CMV Negative

4. Please Mark All Appropriate Areas: HGB \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_  
HGB < 7 gm/dL \_\_\_\_\_ HGB 7-10 gm/dL with other underlying issues \_\_\_\_\_

**A. Risk of Myocardial or Cerebral Ischemia B) Physiological Evidence Pt. needs more Hemoglobin**

\_\_\_ Special Circumstances:

\_\_\_ Chemotherapy patient

\_\_\_ Patient at risk for Myocardial Ischemia

\_\_\_ Coronary Artery Disease

\_\_\_ Valvular Heart Disease

\_\_\_ Congestive Heart Failure

\_\_\_ Risk for Cerebral Ischemia

\_\_\_ History of Transient Ischemia Attacks

\_\_\_ Previous Thrombotic Stroke

\_\_\_ Coagulopathy

\_\_\_ Patient on Chemotherapy

\_\_\_ Maintenance therapy for Chronic Anemia such as Thalassemia \_\_\_ Transient Ischemia Shock

\_\_\_ Acute Bleeding, site \_\_\_\_\_

\_\_\_ During Surgery

\_\_\_ Rapidly Falling Hct

\_\_\_ Syncope

\_\_\_ Dyspnea

\_\_\_ Postural Hypotension

\_\_\_ Oliguria

\_\_\_ Tachycardia

\_\_\_ Angina

\_\_\_ Hct > 30% and invasively monitored patient with supply dependent oxygen consumption (O<sub>2</sub> consumption (VO<sub>2</sub>) increasing with increased O<sub>2</sub> transport (DO<sub>2</sub>)

**NOTE: These are guidelines for blood transfusion practice intended for the review of blood product orders. They are not intended to serve as the sole medical indications for the transfusion.**

Physician Signature: \_\_\_\_\_ M.D. / D.O. Date: \_\_\_\_\_ Time \_\_\_\_\_

Nurse Signature: \_\_\_\_\_ R.N. Date: \_\_\_\_\_ Time: \_\_\_\_\_

**Please place the completed form (Original) in the patient's chart and send the copy to the Laboratory**





Place patient identification sticker and/or two patient identifiers.

PACKED RED BLOOD CELLS (PRBCS)

Ht \_\_\_\_\_ Wt \_\_\_\_\_ kg

ORDERS GOOD FOR THE YEAR OF 20\_\_\_\_\_

ADMIT TO ASU OUTPATIENT

Diagnosis:

Allergies:

Vital Signs:

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:

- 1 Unit PRBCS
- 2 Units PRBCS - if indicated per Blood Transfusion Policy
- Post CBC after 1st unit of PRBCS if requiring 2nd Unit of PRBCS

IF INFUSION-RELATED REACTION OCCURS, FOLLOW BLOOD AND BLOOD PRODUCTS TRANSFUSION POLICY

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
- Diphenhydromine 25mg IV every 15 minutes x2 as needed for urticaria, Pruritis, shortness of breath
- Epinephrine 0.3mg IM x 1 as needed for anaphylaxis
- Methylprednisolone Succinate 125mg IV x 1 as needed for anaphylaxis

NURSING ORDERS

- Monitor patient for 30 minutes after infusion is complete.
- 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
- Other:

Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Qualified Medical Provider Name (Print) : \_\_\_\_\_

Signature: \_\_\_\_\_ NPI# \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

