

BLOOD TRANSFUSION PRE-CRITERIA FORM

Phone: (844)484-8483 / Fax: (844)484-8483

Facility: _____ Date: _____

Nurse/Contact: _____ Phone: _____ Ext: _____

Patient Name: _____ Room: _____

DOB: _____ Current H/H: _____ Contraindications/Issues: _____

Clinical Diagnosis: _____

Allergies: _____

List of Present Medications for Last 6 Months (include Dosage & Frequency) or ATTACH:

History of Transfusions (if any, write dates of transfusions):

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

 Reactions? **Y** **N** (if yes, describe):

Alert and Oriented?	Y N	If NO, POA/ Legal Guardian information must be provided for consent: Name: _____ Number: _____
Combative?	Y N	If YES, PRN order for sedative required.
Dialysis Patient?	Y N	Nephrologist/MD: _____ If YES, nephrologist/MD clearance required. Clearance Obtained: Y N
Receiving Coumadin?	Y N	If YES, INR within past 7 days: Result: _____ Date: _____ (*NOTE: MD APPROVAL REQUIRED IF INR ABOVE 2.5)

Patient Name _____

Date of Birth _____

CONSENT FOR BLOOD PRODUCT TRANSFUSION

This consent form authorizes **IV National LLC** to administer _____ for the treatment of

_____ as per the ordering physician, _____.

I understand that State law guarantees my right to receive information about my health care and to make decisions about my health care in partnership with my doctor. This document provides me with that information. Upon request, I have the opportunity to discuss this information further with my doctor.

PROPOSED TREATMENT: I understand that I need a transfusion as part of my treatment to correct a deficiency of my blood or its parts. This transfusion may be needed for: disease process, or various blood diseases; replacing blood or blood parts that my body is unable to completely produce.

I understand that the blood or blood products that I need may include any or all of the following parts, depending upon the nature of my medical condition:

- Red cells to carry oxygen to tissues or organs;
- Platelets to promote clotting;
- Plasma (the protein fluid part of blood) to replace the essential proteins needed for blood clotting;
- Factor concentrates to replace essential proteins needed for blood clotting.

I understand that when my doctor decides I need a transfusion, a small blood sample will be collected and labeled for testing prior to any transfusion. The sample will be sent to the blood bank for transfusion testing to select a well-matched unit of donor blood. Before transfusion, the nurse will check the label and my armband to make sure that I am receiving the unit specifically matched for me.

I understand that stable IV access must be obtained for a blood transfusion. A licensed practitioner who is qualified to perform the Midline insertion procedure will come to your bedside to attempt placement if deemed necessary. This catheter inserted into your arm through a vein. The catheter may extend up the arm into the chest (depending upon catheter type as ordered by physician/licensed independent practitioner).

I consent to the insertion of a midline. I also acknowledge and understand that the insertion and use of the Midline catheter may involve certain risks, including but not limited to, infection, vein inflammation, pain, catheter or air embolism, and bleeding, and accept such risks. I further acknowledge that I understand the above and have had all my questions answered to my satisfaction.

EXPECTED RESULTS AND BENEFITS: I understand that the transfusion of blood or its parts as listed above is being given to correct a deficiency. The benefits of this transfusion are expected to return my blood or its parts back to levels where they can perform their job in a healthy way.

In the case of red cells, transfusion will very likely increase my blood oxygen carrying capacity and improve the function of my heart and other organs. In the case of platelets, plasma, or factor concentrates, transfusion will very likely improve my blood's ability to form clots in order to minimize the risk of abnormal bleeding.

RISKS: I understand that despite careful transfusion practices followed by my doctors and nurses, there is a chance that I may suffer a transfusion reaction. While most transfusion reactions are mild and easily treated, there is a small risk of

death or permanent disability should I suffer a hemolytic transfusion reaction, a rare but serious form of reaction. Hemolytic reactions occur in about one out of every 70,000 transfusion cases. I am also aware there is a small risk for lung injury, known as transfusion related acute lung injury (TRALI), a serious and life-threatening allergic reaction of my lungs to the donor blood product. TRALI reactions occur in about one out of every 190,000 transfusion cases. I have been informed that while there is a small risk of a life-threatening transfusion reaction, my health care team is trained to recognize the symptoms, perform an appropriate medical evaluation, and provide treatment for the transfusion reaction in the unlikely event that a reaction should occur. I understand that blood and its products are screened at the Blood Bank for matching with my blood to reduce the chances of these serious reactions.

I understand that the blood and its components are voluntarily donated to the Blood Bank, which uses appropriate practices to select donors, collect and test individual units of blood. As a result, there is only a very small risk of an infectious disease being transfused to me. Despite this, there is a small risk of the following types of infection from transfusion: bacteria; malaria; hepatitis C; HIV; or another infectious agent. The known risk of transfusion of hepatitis C is about one out of 140,000 units transfused. The known risk of transfusion of HIV is about one out of 2.5 million units transfused. Between 1985 and 2005, the Blood Bank reported that no patient had contracted HIV from blood or blood products furnished by the Blood Bank.

ALTERNATIVE TREATMENT: I am aware that there are treatment alternatives to transfusion, including the choice of not being transfused. Options may include infusion of non-blood products, such as vitamins, to help my bone marrow produce blood components; colony stimulating factors to promote blood cell growth; or other drugs to either support my blood system or minimize the effects of the deficiency.

I understand that each of these options is less effective and less rapid-acting than the direct transfusion of blood or its parts. I understand that refusal of transfusion of blood may cause serious strain on my heart or other organs due to anemia, and could lead to heart attack, stroke, other life-threatening medical conditions, as well as death. I understand that refusal of transfusion of platelets, plasma, or factor concentrates may lead to excessive bleeding which could lead to conditions including but not limited to injury to other organs, infection, heart attack, stroke, or death.

CONSENT or REFUSE TO CONSENT: I understand that I have the opportunity to speak to my treating provider about transfusion of blood or blood products, and to discuss in more detail the risks and benefits of transfusion, and the alternative treatments and their likely consequences. I understand that I can ask additional questions and can refuse or withdraw from treatment at any time without affecting my continued access to health care services.

By signing this document, I certify that I understand the risks, benefits and alternatives for this procedure, and that I have had an opportunity to ask questions and to have them answered by my provider. **I consent and agree to the insertion and use of a midline catheter (if deemed necessary) and to receive the transfusion services described above.**

Patient Signature: _____ Date: _____

Legal Guardian Name: _____ Signature: _____ Date: _____

Verbal Consent Obtained: YES / NO From Who: Patient / Guardian

*Name of MD or RN Obtaining Consent _____ Signature: _____ Date: _____

*Name of Witness RN: _____ Signature: _____ Date: _____

*** BOTH SIGNATURES OF OBTAINING MD/RN AND WITNESS RN ARE REQUIRED**

Patient Information

Patient First _____ Patient Last _____ DOB _____

Facility _____ Room # _____ Physician: _____

Product Order

Current H/H: _____ *If hemoglobin is above 7.5, please describe symptoms below.

*** 1 unit typically raises Hemoglobin by 1 g/dl and Hematocrit by 2-3% * (see choosingwisely.org)**

Order: PRBC ☐ x1 ☐ x2 Platelet: ☐ x1 *(Check only one option)*

☐ CMV Negative ☐ Sickle Cell Negative ☐ Irradiated ☐ Antigen Negative for: _____ Other: _____

Notes: _____

***ALL CHECK BOXES BELOW ON THE LEFT MUST BE CHECKED OFF BY FACILITY RN ***

Consult

- ☐ Assess patient's vascular condition
- ☐ Establish appropriate vascular access for transfusion per Device Selection Protocol. Insert PIV or Midline if necessary
- ☐ Obtain Type and Cross for blood product transfusion

Pharmacy Supplies

- ☐ IV Infusion pump for blood product infusion
- ☐ Blood product approved tubing (1 for every unit)
- ☐ Normal saline 500mL or greater (1 for every unit)

Transfusion

- ☐ Assessment of Vital Signs, Lung Sounds and IV site will be performed:
 - Before start of transfusion
 - 15 minutes after start of transfusion
 - 30 minutes after start of transfusion
 - Q 1 hour until transfusion complete
 - 1-hour post-transfusion
- ☐ IV access care and maintenance per facility protocol

Notification

- ☐ Notify Facility Ordering Physician if:
 - T >101°F, SBP <90, RR > 26, HR > 110
 - Abnormal breath sounds or change from baseline
 - Any S/Sx of transfusion reaction (see acute transfusion reaction policy)

Transfusion Reaction

- ☐ Manage reaction per protocol:
 - Diphenhydramine 25mg PO/GT x1 for mild Allergic Transfusion Reaction
 - Diphenhydramine 50mg IV x1 for severe Allergic Transfusion Reaction
 - Solumedrol 125mg IV x1 for severe Allergic Transfusion Reaction
 - Tylenol 650mg x1 PO/GT for fever >101°F
 - Lasix 20mg IV x1 for mild Transfusion Fluid Overload
 - Lasix 40mg IV x1 for severe Transfusion Fluid Overload
 - Epinephrine 1:1000 (0.5mg/0.5ml) 0.5ml IM x1, repeat at 5-10 min intervals if required for Anaphylaxis

WHEN COMPLETED, PLEASE DO THE FOLLOWING AS EARLY AS POSSIBLE AND BEFORE 2PM:

1. Upload / Photo & submit on ivcentric.com home page - Green Tab OR Fax to 1844 484 8483
2. Text "Blood Transfusion" to 6463842277

Name of Ordering MD/NP/PA: _____ MD/NP/PA Direct Contact #: _____

The above order is confirmed with provider and is in the EMR? **Y / N**

Date/Time: _____ RN Signature & Initials: _____