AUTOMATIC STOP ORDERS

ORAL ANTICOAGULANTS—	AFTER 24 HOURS
ALBUMIN—	AFTER 24 HOURS
LARGE VOLUME INTRAVENOUS—	AFTER 24 HOURS
INJECTABLE ANTICOAGULANTS (SC)—	AFTER 5 DAYS
CONTROLLED SUBSTANCES—	AFTER 5 DAYS
CORTISONE PRODUCTS—	AFTER 5 DAYS

MD Date of Order	Hour of Order	Nurse's Signature	NURSE: PLEASE X IN COLUMN ON LINE, FOR MEDICATIONS REQUIRED FROM PHARMACY PHYSICIAN MUST ENTER DATE, HOUR, AND SIGN EACH SET OF ORDERS.

Pediatrics/Neonates: Weight (Kg) ______ Gestational Age (Premature Infants Only) ______

Postmenstrual Age (Premature Infants Only) ______

ALLERGIES:

ORDERS FOR BLOOD TRANSFUSION (not to be used for type/screen or type/cross)
(Check appropriate boxes and fill in the blanks)

Physicians: Please complete the following when ordering a transfusion. The transfusion indications noted below are guidelines for use of blood and blood products and are not a substitute for medical judgement. Please document any additional indications under "other".

☐ **Packed Cells:** ______ # Units ______ # CC ______ Hgb/Hct
- ☐ Acute blood loss with ≤ Hgb 8 gms or HCT ≤ 24%
- ☐ Hemodynamically significant blood loss
- ☐ Symptomatic chronic anemia
- ☐ Other: ______

☐ **Fresh Frozen Plasma:** ☐ **SD Plasma:**
______ # Units ______ # CC ______ PT/PTT
- ☐ Replacement of single or multiple coagulation factor deficiency (when concentrate preparations not available)
- ☐ Dilutional cuagulopathy 2° massive transfusions (≥ 10 consecutive units)
- ☐ Treatment of Thrombotic Thrombocytopenic Purpura (TTP) or Hemolytic Uremic Syndrome (HUS)
- ☐ Reversal of warfarin effect
- ☐ Deficiency of AT III (when concentrate preparation is not available) Heparin Co-factor II, Protein C, Protein S
- ☐ Other: ______

☐ **Platelets:** ______ # Units ______ # PLT Count
- ☐ Platelets ≤ 10,000/mm^3
- ☐ Platelets ≥ 10,000/mm^3 with active bleeding
- ☐ Major surgery with platelets ≤ 50,000/mm^3
- ☐ Platelets < 80,000/mm^3 2° massive transfusions (≥ 10 consecutive units)
- ☐ Other: ______

☐ **Other blood product:** ______

☐ **Irradiated** ☐ **Leukonreduced** ☐ **Other:** ______

☐ **Consent # 2 signed and on chart**

Physician's Signature: ______

DO NOT WRITE IN THIS AREA

THIS SPACE IS FOR PHARMACY

Blood Transfusion Orders Rev. 12/3/04

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PLEASE DO NOT RETURN CHARTS WITH NEW ORDERS TO RACK-FLAG CHART

UNIVERSITY MEDICAL CENTER
PHYSICIANS ORDERS AND TREATMENTS

28.0