Edward-Elmhurst Cancer Centers
120 Spalding Drive; Suite 111; Naperville, IL 60540
Phone: 630/646-2273 Fax: 630/548-6617

24600 W. 127th Street; Plainfield, IL 60585
Phone: 630/646-2273 Fax: 630/548-6617

177 E. Brush Hill Road; Elmhurst, IL 60126
Phone: 630/646-2273 Fax: 331/221-3887

BLOOD TRANSFUSION ORDER FORM

Patient Name: _____ **DOB:** _____

Recent Lab Data: _____

Diagnosis (ICD-10 Required): _____

ORDER INFORMATION (Check One)

☐ Type and Screen ☐ Type and Cross

Check Desired Product and Indicate Quantity:

☐ Packed cells: ____ # Units ☐ Platelets: ____ # Units

Is the patient initiating or receiving Daratumumab (Darzalex) or isatuximab-irfc (Sarclisa) chemotherapy? If so, please contact charge nurse at Cancer Center (Naperville: 630-646-8231; Plainfield: 815-731-8019)

TRANSFUSION INSTRUCTIONS

Date of Transfusion: _____ **Location of Transfusion:** ☐ **Elmhurst** ☐ **Naperville** ☐ **Plainfield**

Transfuse each product over ____ hours Premedication:
☐ Tylenol 650mg po
☐ Benadryl 25mg po
☐ Other: _____

BLOOD PRODUCT ORDERS AND INDICATIONS

(Note: Cannot accept patient with Hgb less than 6.0 as outpatient)

Red Blood Cells (Check ONE Indication)

☐ Symptomatic anemia with Hgb ≤ 7g/dL

☐ Coronary syndrome with Hgb ≤ 9g/dL

☐ Symptomatic anemia with sepsis, CAD or decreased O_2, with Hgb ≤ 10g/dL

☐ Active bleeding

Platelets (Check ONE Indication)

☐ Plt count ≤ 20,000/uL

☐ Plt count ≤ 50,000/uL w/ major surgery, active bleed, or invasive procedure

☐ Plt count ≤ 100,000/uL w/ neuro or optho surgery

********Check ONE Indication if needed OR ☐ Not Applicable*********

Leukocyte Reduced (Red Blood Cells and Platelet ONLY)

- ☐ Bone marrow or stem cell candidate/recipient
- ☐ Cardiothoracic surgical procedure with pulmonary bypass
- ☐ Hematologic malignancy
- ☐ Hemoglobinopathy or other chronic hemolytic anemia
- ☐ Immunosuppressive chemotherapy or bone marrow failure states
- ☐ Severe, repeated febrile transfusion reactions

Gamma Irradiated (Red Blood Cells and Platelet ONLY)

- ☐ Bone marrow or stem cell candidate/recipient
- ☐ Hematologic malignancy
- ☐ High dose chemotherapy or immunosuppression
- ☐ HLA-matched RBC and all directed donors
- ☐ T-cell immunodeficiency

Saline Washed (Red Blood Cells ONLY)

- ☐ Previous anaphylactic transfusion reaction
- ☐ Repeated severe cytokine transfusion reaction
- ☐ Selective IgA deficiency

In the event of a hypersensitivity reaction during the transfusion, we will implement the reaction protocol. A designated nurse practitioner will evaluate your patient and your office will receive notification of the event.

In the event that your patient has a central line, it will be used per the Cancer Center protocol, unless otherwise directed.

Physician Signature: _____ **Date:** _____

Ordering Physician NPI: _____ **Swedish Hospital NPI:** **1831151257**

_____ _____ _____

Physician Name (Please Print) **Office Phone** **Fax Number**

Revision/Review Date: 12/24