



Routine Transfusion Orders Pediatric (adopted from the IWK Health Centre)

Patient: _____
Age: _____ Wt: _____ kg Date of Wt (dd/mm/yyyy): _____
Height: _____ Body Surface Area: _____
Allergies: _____

The following orders will be carried out by a nurse **ONLY ON THE AUTHORITY OF AN AUTHORIZED PRESCRIBER.**
Where choice occurs, check as appropriate.

BLOOD PRODUCTS: Test for ABO, Rh and antibody screen, when required
See Clinical Policy #625: Administration of Blood Products
See Transfusion Reaction Orders

Prime and/or flush line with 0.9% NaCl only, prior to and following any blood product.

Does patient require Irradiated product (packed RBCs & platelets)? Yes No

Does patient require CMV negative product? Yes No

- Packed red blood cells (hemoglobin greater than 50 g/L)**
Transfuse 10 to 15 mL/kg = _____ mL/ or _____ units IV over 3 ½ hours (nearest full unit = 240-340 mL)
(10 to 15 mL/kg should increase the hemoglobin concentration by ~ 25 g/L)
- Packed red blood cells (hemoglobin less than 50 g/L)**
Do not use the following order for patients presenting with an acute bleed.
Transfuse 10% of pre-transfusion hemoglobin level in mL/kg = _____ mL/kg = _____ mL/or _____ units
IV over 3 ½ hours
(EXAMPLE: If pre-transfusion hemoglobin level is 40 g/L, then initial infusion rate is 4 mL/kg IV over 3 ½ hours)
- Platelet concentrates (less than 20 kg):** Transfuse 10 mL/kg = _____ mL IV push or IV over 30-60 minutes.
(10 mL/kg should raise platelet count by ~ 40,000)
- Platelet concentrates (greater than or equal to 20 kg):** Transfuse 1 unit IV push or IV over 30-60 minutes.
(1 unit = 350-400 mL) Does patient require Apheresed product (single donor)? Yes No
- Frozen Plasma:** Transfuse 10-15 mL/kg = _____ mL/or _____ units of plasma, IV over 2-4 hours
(nearest full unit = approximately 250 mL or 500 mL)
NOTE: **given when reported ATIII level is less than 50% of the lab lower limit of normal range**
- Cryoprecipitate:** Transfuse with 6 units/m² = _____ units or 1 unit/5 kg = _____ units, IV push
(Should increase plasma fibrinogen by 1 g/L.) NOTE: **give when fibrinogen level less than 1 g/L**

Rh negative patients:

Give prior to first RH + platelet transfusion (or within 72 hours post transfusion). Note: filter not required.

- Rho(D) immune globulin** IV WinRho SDF™ 300 micrograms IV push. Repeat after a total of 8 doses of platelets have been transfused and repeat if platelets required more than 4 weeks since last dose of WinRho SDF™.
OR
If Child is expected to receive fewer than 3 doses of platelets within a 4 week period:
- Rho(D) immune globulin** IV WinRho SDF™ 120 micrograms IV push. Repeat after a total of 3 doses of platelets have been transfused and repeat if platelets required more than 4 weeks since last dose of WinRho SDF™.

DATE (dd/mm/yyyy) Time (24hr/hh:mm) Prescriber Signature Printed Surname/Registration#

DATE (dd/mm/yyyy) Time (24hr/hh:mm) Verified By (Nurse Signature) Printed Surname