

Health Record #: _____	Complete or place barcoded patient label here
Patient Name: <i>(Print first, last)</i> _____	
DOB: <u>dd</u> / <u>mm</u> / <u>yy</u>	Age: _____ <input type="checkbox"/> Female <input type="checkbox"/> Male
OHIP #: _____	Version Code: _____
Account #: _____	Date of Admission: <u>dd</u> / <u>mm</u> / <u>yy</u>

## Infusion Clinic Referral Form

**Fax to 905-952-2468**

PATIENT INFORMATION		INCOMPLETE FORMS WILL NOT BE PROCESSED	
Patient Name: <i>(print first, last)</i>		Date of Birth: <u>dd</u> / <u>mm</u> / <u>yy</u>	
Patient Address: <u>Street Number + Name</u>	<u>Apartment</u>	<u>City</u>	<u>Province</u> <u>Postal Code</u>
Health Card Number:	Version Code:	MRN:	
Primary Phone:		Other Phone:	
REFERRAL INFORMATION			
<b>Appointment Reason</b>			
<i>Only first dose infusions will be booked at the Infusion Clinic, any subsequent infusions must be referred to a community clinic:</i>			
<input type="checkbox"/> Iron / Sucrose / Venofer <input type="checkbox"/> Pamidronate <input type="checkbox"/> Solucortef <input type="checkbox"/> Monoferric:* <input type="radio"/> 1 dose <input type="radio"/> 2 doses 1 week apart <i>*if the dose requires 2 infusions, 2 appointments will be scheduled; all future infusions must be referred to a community clinic.</i>			
<div style="border: 2px solid red; padding: 5px; color: red; font-weight: bold;">           THIS IS NOT AN ORDER - medication orders must be entered into Meditech         </div>			
<input type="checkbox"/> Albumin <input type="radio"/> Albumin 25% IV 100 ml x _____ dose for every _____ litres drained <b>OR</b> <input type="radio"/> Albumin 25% IV 100 ml x _____ doses <span style="color: red; font-weight: bold;">If booking IVIG or platelet infusions please see pages 2 to 5</span>			
PLEASE READ - IMPORTANT REMINDERS			
For physicians with privileges at Southlake Health, ADC IV Infusion Order Set, or any other infusion orders MUST be entered electronically in the patient's Meditech account under the Hold Queue for clinic use.			
Please advise the <b>patient to bring their prescribed iron medication to their appointment</b> . Appointments may need to be rescheduled if medication is not brought. Medication may be obtained from the pharmacy of choice.			
BY SIGNING THIS FORM, I CONFIRM THAT THIS PATIENT IS AWARE OF THIS REFERRAL			
<b>Referred by:</b> Check (✓) one <input type="checkbox"/> Family Physician <input type="checkbox"/> Nurse Practitioner			
Ordering Provider Name: <i>(print first, last)</i>			Billing #:
Date of Referral: <u>dd</u> / <u>mm</u> / <u>yy</u>	Signature:		
Phone Number:		Fax Number:	
Family Provider Name if not Ordering Provider: <i>(print first, last)</i>			Billing #:





Leading Edge Care. Close to Home.

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Pharmacy STAT Barcode

Allergies:  NKA, or: \_\_\_\_\_

Guide: 1. Where tick boxes are offered, only tick orders that are to be pursued.  
2. If completing on hard copy: a) Use BLACK ballpoint. b) Where appropriate, draw a line through orders not needed & initial.

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<b>Adult Human IV Immunoglobulin (IVIG) Therapy Order Set</b>	<b>ACTION CODE</b>
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**\*\*\*Ministry of Health and Long Term Care (MOHLTC) IVIG Request Form  
(either Neurological or non-Neurological) to be completed by ordering prescriber\*\*\***

Indication:  Non-Neurological  Neurological  
 Diagnosis: \_\_\_\_\_  
 \_\_\_\_\_  
 MRP: \_\_\_\_\_  
 Date of Treatment: dd / mm / yy  
 Weight \_\_\_\_\_ kg Height \_\_\_\_\_ cm  
 Dosing Weight \_\_\_\_\_ kg (calculate using dosing calculator found on Transfusion Ontario Website)

**Consent**

Verify consent discussion as per Blood and/or Blood Products - Consent/Refusal of Consent for Transfusion policy (A B010) and confirm Patient's Consent/Refusal of Consent for Transfusion of Blood and/or Blood Products form (SL1271-B) has been signed and is on the patient's chart

**Vitals/Monitoring**

Vitals signs (Temp, HR, RR, BP, SpO<sub>2</sub>):

- Just prior to the start of the infusion and 15 minutes after start of transfusion
- Prior to each infusion rate increase or change
- Once maximum titration is reached q1h and PRN
- Recheck 30 minutes after the infusion has ended

**Lab Investigations**

**Pre-transfusion**

CBC  IgG (if required for Non-Neurology patients)  Group and Screen (For initial IVIG infusion)  
 Other: \_\_\_\_\_

**IV Therapy**

**\*\*IVIG is not compatible with 0.9% NaCl\*\***

IV Fluid:  D5W IV TKVO when IVIG not infusing

**Pre-transfusion Medications**

**\*\*\*Give 30 minutes prior to start of IVIG infusion\*\*\***

**\*\*\*max Acetaminophen from all sources 4,000 mg in 24 hours\*\*\***

Acetaminophen 650 mg PO x 1 PRN  
 diphenhydrAMINE 25 mg IV x 1 PRN  
 Hydrocortisone 100 mg IV x 1 PRN



Practitioner's Signature: _____ <small>Signature (Include Professional Designation)</small>	CPSO/RHP# or Printed Name: _____ <small>(Print. MDs use CPSO #.)</small>	Date _____ <small>(DD/MM/YY)</small>	Time _____ <small>(24 hrs)</small>	<input type="checkbox"/> Scanned to Pharmacy
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<b>Adult Human IV Immunoglobulin (IVIG) Therapy Order Set</b>	<b>ACTION CODE</b>
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**Human IV Immunoglobulin**

\*\*\*IVIG infusion instructions (standardized for all brands)\*\*\*  
 \*\*\*Dose Calculator can be found on Transfusion Ontario Website  
<http://www.transfusionontario.org/dose>\*\*\*

Ensure Anaphylaxis Kit at bedside (outpatient clinics)

**IVIG Dose**

Induction/One-time dose

**OR**

Maintenance dose

Dose: \_\_\_\_\_ g/kg

Total dose: \_\_\_\_\_ g

Dose frequency \_\_\_\_\_

**IVIG Rate**

IVIG infusion as below, increase as indicated **ONLY** if vital signs stable

**START** at 0.5 mL/kg/hour for 30 minutes

**THEN** 1 mL/kg/hour for 30 minutes

**THEN** 2 mL/kg/hour for 30 minutes

**THEN** increase to maximum 4 mL/kg/hour until total dose completed.

**Management of Hypersensitivity/Anaphylaxis**

If suspected adverse reaction occurs, STOP transfusion immediately and notify MRP STAT

If adverse reaction occurs, once patient is stabilized, complete Notification of Transfusion Reaction form (SL0028) and forward both copies to Transfusion Medicine. Include a post-transfusion blood sample, first post-transfusion urine sample (if available) and the implicated product, including administration set

**Hypersensitivity Medication management.**

\*\*\*Give following meds for management of hypersensitivity reaction. \*\*\*

\*\*\*max Acetaminophen from all sources 4,000 mg in 24 hours\*\*\*

Acetaminophen 650 mg PO x 1 PRN

diphenhydramine 25 – 50 mg IV x 1 PRN

Hydrocortisone 100 mg IV x 1 PRN

Other: \_\_\_\_\_

**Additional Orders:**

Practitioner's

Signature: \_\_\_\_\_

Signature (Include Professional Designation)

CPSO/RHP# or

Printed Name: \_\_\_\_\_

(Print. MDs use CPSO #.)

Date \_\_\_\_\_

(DD/MM/YY)

Time \_\_\_\_\_

(24 hrs)

Co-Signature

(if applicable): \_\_\_\_\_

Signature (Include Professional Designation)

CPSO/RHP# or

Printed Name: \_\_\_\_\_

(Print. MDs use CPSO #.)

Date \_\_\_\_\_

(DD/MM/YY)

Time \_\_\_\_\_

(24 hrs)

Scanned to Pharmacy



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<b>Platelet Transfusion (Non-emergent) Order Set</b>	<b>ACTION CODE</b>										
<p style="text-align: center;"><b>Consent</b></p> <p><input checked="" type="checkbox"/> Verify that consent for blood product transfusion is on chart</p> <p style="text-align: center;"><b>Vitals/Monitoring</b></p> <p><input checked="" type="checkbox"/> Vital signs/monitoring as per Blood Transfusion and/or Blood Products – Intravenous – Care of the Patient Standard of Care (VA B003)</p> <p style="text-align: center;"><b>Lab Investigations</b></p> <p><input type="checkbox"/> Group + Screen</p> <p><b>60 minutes post transfusion</b></p> <p><input type="checkbox"/> CBC</p> <p><b>In a.m. day following transfusion</b></p> <p><input type="checkbox"/> CBC</p> <p>Additional Labs: _____</p> <p style="text-align: center;"><b>IV Therapy</b></p> <p><input checked="" type="checkbox"/> 0.9% NaCl IV TKVO</p> <p style="text-align: center;"><b>Pre-transfusion Medications</b></p> <p><b>***Consider use in patients with history of mild allergic or febrile transfusion reactions***</b></p> <p><input type="checkbox"/> diphenhydr<b>AMINE</b> _____ mg IV x 1 prior to transfusion (25 – 50 mg)</p> <p><input type="checkbox"/> Acetaminophen 650 mg PO/PR x 1 prior to transfusion</p> <p style="text-align: center;"><b>Blood Product Transfusion</b></p> <p><b>***If transfusion not started within 30 minutes of receipt, product MUST be returned immediately to the Blood Bank***</b></p> <p><input checked="" type="checkbox"/> Transfuse _____ dose(s) of platelets over _____ hour(s)</p> <p><input type="checkbox"/> Irradiated    <input type="checkbox"/> CMV negative    <input type="checkbox"/> HLA matched</p> <p>Indication: <input type="checkbox"/> Platelet count less than 10 x 10<sup>9</sup>/L (Non-immune thrombocytopenia)</p> <p><input type="checkbox"/> Platelet count less than 50 x 10<sup>9</sup>/L (Undergoing invasive procedure)</p> <p><input type="checkbox"/> Platelet dysfunction with bleeding</p> <p>Other: _____</p>											
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Find height & weight in electronic medical record.

Allergies:  NKA, or: \_\_\_\_\_

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<b>Packed Red Blood Cells Transfusion (Non-emergent) Order Set</b>	ACTION CODE										
Weight _____ kg											
<b>Consent</b>											
<input checked="" type="checkbox"/> Verify that consent for blood product transfusion is on chart											
<b>Vitals/Monitoring</b>											
<input checked="" type="checkbox"/> Vital signs/monitoring as per Blood Transfusion and/or Blood Products – Intravenous – Care of the Patient Standard of Care (VA B003)											
<b>Lab Investigations</b>											
<input type="checkbox"/> Group + Screen _____ units packed red blood cells for <u>dd</u> / <u>mm</u> / <u>yy</u>											
<b>60 minutes post transfusion</b>											
<input type="checkbox"/> CBC											
<b>In a.m. day following transfusion</b>											
<input type="checkbox"/> CBC											
Additional Labs: _____											
<b>IV Therapy</b>											
<input checked="" type="checkbox"/> 0.9% NaCl IV TKVO											
<b>Pre-transfusion Medications</b>											
<b>***Consider use in patients with history of mild allergic or febrile transfusion reactions***</b>											
<input type="checkbox"/> diphenhydr <b>AMINE</b> _____ mg IV x 1 prior to transfusion (25 – 50 mg)											
<input type="checkbox"/> Acetaminophen 650 mg PO/PR x 1 prior to transfusion											
<b>Blood Product Transfusion</b>											
<b>***If transfusion not started within 30 minutes of receipt, product MUST be returned immediately to the Blood Bank***</b>											
<input checked="" type="checkbox"/> Transfuse _____ unit(s) of packed red blood cells each over _____ hour(s)											
<input type="checkbox"/> Irradiated <input type="checkbox"/> CMV negative											
<input checked="" type="checkbox"/> Start transfusion at 1 mL/kg/hour x 15 minutes, then if no adverse reaction occurs, increase to full rate											
Indication: <input type="checkbox"/> Active Blood Loss <input type="checkbox"/> Symptomatic Anemia											
<input type="checkbox"/> Hemoglobin between 70 – 80 g/L and patient symptomatic											
<input type="checkbox"/> Hemoglobin less than 70 g/L											
<input type="checkbox"/> Hemoglobin above 70 g/L for asymptomatic patients with heart disease											
Other: _____											
<input type="checkbox"/> Furosemide _____ mg IV x 1 to be given <input type="checkbox"/> Between units <input type="checkbox"/> At completion of transfusion											
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