**BLOOD PRODUCT TRANSFUSION ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HT: \_\_\_\_\_\_\_\_\_\_ in. WT: \_\_\_\_\_\_\_\_ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Phone # \_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tax ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STATEMENT OF MEDICAL NECESSITY**

Primary Diagnosis: (ICD 10 CODE + DESCRIPTION) Secondary Diagnosis: (ICD 10 CODE + DESCRIPTION)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERTINENT MEDICAL HISTORY**

Does patient have venous access? **YES NO If yes, what type MEDIPORT PIV PICC LINE OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1) Is the patient incontinent? 🞅 Yes 🞅 No 2) Is the patient ambulatory? 🞅 Yes 🞅 No

2) Has the patient taken Darzalex within the last 6 months? **YES NO**

3) Has type and cross been drawn? YES NO If yes, date and time \_\_\_\_\_\_\_\_\_\_\_. If no, patient instructed to go to MMC lab on \_\_\_\_\_\_\_\_\_ date/time OR \_\_\_\_\_\_\_\_\_ to be drawn at Infusion Center on arrival.

NOTES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRESCRIPTION ORDERS:**

A) ALL MEDIPORTS / IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL PRN

B) 250 cc BAG OF 0.9% NS MAY BE HUNG WITH EACH BLOOD PRODUCT TRANSFUSION

C) TUBING WILL BE FLUSHED WITH 0.9% NS UNTIL TUBING IS PINK TINGED OR CLEAR

D) H+H MUST BE COMPLETED WITHIN ONE WEEK OF ALL BLOOD PRODUCT TRANSFUSIONS

**TYPE, CROSSMATCH, AND TRANSFUSE: LABS**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **SELECT** | **# of UNITS**  | **PRODUCT** |  | **SELECT**  | **LAB REQUESTED** | **WHEN** |
|  |  | **FRESH FROZEN PLASMA** |  |  | **NONE** | **NA** |
|  |  | **LEUKO REDUCED PRBCs** |  |  | **BMP** | **( ) PRIOR ( ) POST** |
|  |  | **LEUKO REDUCED IRRADIATED PRBCs** |  |  | **CMP** | **( ) PRIOR ( ) POST** |
|  |  | **LEUKO REDUCED PLATELETS** |  |  | **CBC w/ DIFF** | **( ) PRIOR ( ) POST** |
|  |  | **LEUKO REDUCED IRRADIATED PLATELETS** |  |  | **H+H:** | **( ) PRIOR ( ) POST** |
|  |  | **PLATELETS TYPE SPECIFIC**? **🞅 Yes OR 🞅 No**  |  |  | **T+C:** | **( ) PRIOR ( ) POST** |
|  |  | **Other:** |  |  | **Other:** | **( ) PRIOR ( ) POST** |

**PREMEDS NOTES/INSTRUCTIONS/COMMENTS**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SELECT**  | **MEDICATION** | **DOSE** | **ROUTE** | **FREQUENCY** |
|  | **NONE** | **NA** | **NA** | **NA** |
|  | **BENADRYL** |  |  |  |
|  | **ACETAMINOPHEN** |  |  |  |
|  | **OXYGEN** |  |  |  |
|  | **LASIX**  |  |  |  |
|  | **Other:** |  |  |  |

**DIETARY RESTRICTIONS (If none, please indicate): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Signature Must Be Clear and Legible*

**Co-signature (If Required) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Signature Must Be Clear and Legible*

**GASTROENTEROLOGY ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HT: \_\_\_\_\_\_\_\_\_\_ in. WT: \_\_\_\_\_\_\_\_ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Physician Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Phone # \_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tax ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STATEMENT OF MEDICAL NECESSITY**

Primary Diagnosis: ICD-10 Code plus Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERTINENT MEDICAL HISTORY**

Does patient have venous access? **YES NO If yes, what type MEDIPORT PIV PICC LINE OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1)TB test performed? 🞅 Yes 🞅 No Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***TB testing will be completed per ACR Guidelines and hospital policy.***

2) Patient diagnosed with Congestive Heart Failure? 🞅 Yes 🞅 No 3)Liver function test normal? 🞅 Yes 🞅 No

4) Patient previously treated with Entyvio OR Remicade OR Simponi Aria? 🞅 Yes 🞅 No Please select: 🞅 Entyvio 🞅 Remicade 🞅 Simponi Aria Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5) Hep-B antigen surface antibody test? 🞅 Yes 🞅 No Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRESCRIPTION ORDERS:**

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL

b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED PER STANDARD PHARMACY CONCENTRATIONS AND HOSPITAL POLICY

c)DOSES MAY BE ROUNDED TO NEAREST VIAL SIZE WITHIN 10% OF PERSCRIBED DOSE. WEIGHT BASED DOSING WILL REMAIN FOR DURATION OF ORDER UNLESS WEIGHT CHANGES +/- BY \_\_\_\_\_\_ %

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SELECT**  | **DOSING OPTIONS** | **DOSE** | **ROUTE** | **FREQUENCY (POPULATE BELOW)** | **DURATION** |
|  | **ENTYVIO LOADING DOSES** | **300 MG** | **IV** | **0, 2, 6 WEEKS, THEN ONCE EVERY 8 WEEKS** |  |
|  | **ENTYVIO MAINTENANCE DOSE** | **300 MG** | **IV** | **ONCE EVERY 8 WEEKS** |  |
|  | **REMICADE / INFLECTRA (CIRCLE ONE)****LOADING DOSES** | **\_\_\_ MG / \_\_\_\_KG= \_\_\_\_\_ MG**  | **IV** | **0, 2, 6 WEEKS, THEN ONCE EVERY WEEKS****RATE: RAPID or STANDARD**  |  |
|  | **REMICADE / INFLECTRA (CIRCLE ONE)****MAINTENANCE DOSES** | **\_\_\_ MG / \_\_\_\_KG= \_\_\_\_\_ MG**  | **IV** | **ONCE EVERY WEEKS****RATE: RAPID or STANDARD**  |  |
|  | **REMICADE / INFLECTRA (CIRCLE ONE)****FLAT DOSE** |  **MG** | **IV** | **ONCE EVERY WEEKS****RATE: RAPID or STANDARD**  |  |

**PREMEDS LABS**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SELECT**  | **MEDICATION** | **DOSE** | **ROUTE** |  | **SELECT**  | **LAB REQUESTED** | **WHEN** | **FREQUENCY** |
|  | **NONE** | **NA** | **NA** |  |  | **NONE** | **NA** | **NA** |
|  | **BENADRYL** |  |  |  |  | **BMP** | **( ) PRIOR ( ) POST** |  |
|  | **ACETAMINOPHEN** |  |  |  |  | **CMP** | **( ) PRIOR ( ) POST** |  |
|  | **OXYGEN** |  |  |  |  | **BUN/CREATININE** | **( ) PRIOR ( ) POST** |  |
|  | **SOLU-MEDROL** |  |  |  |  | **CRP** | **( ) PRIOR ( ) POST** |  |
|  | **Other:** |  |  |  |  | **ESR** | **( ) PRIOR ( ) POST** |  |
|  | **Other:** |  |  |  |  | **ALT** | **( ) PRIOR ( ) POST** |  |
|  | **Other:** |  |  |  |  | **AST** | **( ) PRIOR ( ) POST** |  |
|  | **Other:** |  |  |  |  | **LIVER PANEL** | **( ) PRIOR ( ) POST** |  |
|  | **Other:** |  |  |  |  | **VECTRA** | **( ) PRIOR ( ) POST** |  |
|  | **Other:** |  |  |  |  | **OTHER:** | **( ) PRIOR ( ) POST** |  |

**NOTES/INSTRUCTIONS/COMMENTS**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Signature Must Be Clear and Legible*

**Co-signature (If Required) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Signature Must Be Clear and Legible*

**GENERAL IV ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HT: \_\_\_\_\_\_\_\_\_\_ in. WT: \_\_\_\_\_\_\_\_ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Phone # \_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tax ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STATEMENT OF MEDICAL NECESSITY**

Primary Diagnosis: (ICD 10 CODE + DESCRIPTION) Secondary Diagnosis: (ICD 10 CODE + DESCRIPTION)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does patient have venous access? **YES NO If yes, what type MEDIPORT PIV PICC LINE Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRESCRIPTION ORDERS**

1. ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH HEPARIN OR SALINE PER HOSPITAL PROTOCOL PRN

***PLEASE SELECT FROM BELOW:***

\_\_\_\_\_\_ Perform port flush every \_\_\_\_\_\_\_\_ weeks per hospital protocol.

\_\_\_\_\_\_ Perform IV site care per hospital protocol.

\_\_\_\_\_\_ Activase 2mg IVP per hospital protocol.

**NOTE: For patients with central venous access, please select: D/C AFTER LAST DOSE**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

 **DRUG 1 DOSE ROUTE FREQUENCY DURATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

 **DRUG 2 DOSE ROUTE FREQUENCY DURATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

 **DRUG 3 DOSE ROUTE FREQUENCY DURATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |

 **DRUG 4 DOSE ROUTE FREQUENCY DURATION**

**LABS NOTES/INSTRUCTIONS/OTHER**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **SELECT BELOW** | **LAB REQUESTED** | **FREQUENCY** |
|  | **NONE** | **NA** |
|  | **CBC w/ Diff** |  |
|  | **BMP** |  |
|  | **CMP** |  |
|  | **BUN/CREATININE** |  |
|  | **ESR** |  |
|  | **CRP** |  |
|  | **CPK** |  |
|  | **Other:** |  |
|  | **Other:** |  |

**Physician’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Signature Must Be Clear and Legible*

**Co-signature (If Required) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Signature Must Be Clear and Legible*

**HYDRATION ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HT: \_\_\_\_\_\_\_\_\_\_ in. WT: \_\_\_\_\_\_\_\_ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Physician Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Phone # \_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tax ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STATEMENT OF MEDICAL NECESSITY**

Primary Diagnosis: (ICD 10 CODE) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERTINENT MEDICAL HISTORY**

Does patient have venous access? **YES NO If yes, what type MEDIPORT PIV PICC LINE OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. ALL MEDIPORTS/IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL

**PRESCRIPTION ORDERS FOR HYDRATION Select the fluid requested AND the corresponding rate below**

1.  **NORMAL SALINE 2.)**  **LACTATED RINGERS**

** 500 mls, IV x  500 mls, IV x**

** 1000 mls (1 Liter), IV x  1000 mls (1 Liter), IV x**

** 2000 mls (2 Liters), IV x  2000 mls (2 Liters), IV x**

 **RATE RATE**

** BOLUS - GIVEN OVER 1 HOUR  BOLUS - GIVEN OVER 1 HOUR**

** Over 2 hours @ mls/hour  Over 2 hours @ mls/hour**

** Over 4 hours @ mls/hour  Over 4 hours @ mls/hour**

** Other: mls/hour  Other: mls/hour**

** ADDITIVES: 🞅 \_\_\_\_\_\_\_ MEQ K+ 🞅 \_\_\_\_\_\_\_MG MAG 🞅OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RATE MAY BE ADJUSTED PER HOSPITAL POLICY, (K+ max rate of 10mEq/hr)**

**OTHER (PLEASE SPECIFY DRUG, RATE, FREQUENCY, AND DURATION BELOW:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**LABS: NOTES/INSTRUCTIONS/COMMENTS**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **SELECT BELOW** | **LAB REQUESTED** | **FREQUENCY** |
|  | **NONE**  | **NONE** |
|  | **CBC w/ Diff** | **( ) PRIOR ( ) POST** |
|  | **BMP** | **( ) PRIOR ( ) POST** |
|  | **CMP** | **( ) PRIOR ( ) POST** |
|  | **BUN/CREATININE** | **( ) PRIOR ( ) POST** |
|  | **Other:** | **( ) PRIOR ( ) POST** |

**Physician’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Signature Must Be Clear and Legible*

**Co-signature (If Required) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Signature Must Be Clear and Legible*

**NEUROLOGY ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HT: \_\_\_\_\_\_\_\_\_\_ in. WT: \_\_\_\_\_\_\_\_ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Physician Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Phone # \_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tax ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STATEMENT OF MEDICAL NECESSITY**

Primary Diagnosis: ICD 10 + Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERTINENT MEDICAL HISTORY**

Does patient have venous access? **YES NO If yes, what type MEDIPORT PIV PICC LINE OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRESCRIPTION ORDERS:**

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL

b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED PER STANDARD PHARMACY CONCENTRATIONS AND HOSPITAL POLICY

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SELECT**  | **MEDICATION / DOSE** | **ROUTE**  | **RATE** | **FREQUENCY** | **DURATION** |
|  | **TYSABRI 300MG****\*PATIENT WILL BE OBSERVED FOR 1 HOUR POST INFUSION** | **IV** | **Over 1 Hour** |  | **12 MONTHS** |
|  | **OCREVUS LOADING DOSES** | **IV** |  | **300 mg at 0, 2 weeks, then 600mg once every 6 months** |  |
|  | **OCREVUS 600MG MAINTANENCE DOSES** | **IV** |  | **Once every 6 months** |  |
|  | **SOLU-MEDROL \_\_\_\_\_\_\_ MG/ \_\_\_\_\_\_\_\_\_\_\_ML**  | **IV** |  |  |  |

**PREMEDS LABS**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SELECT**  | **MEDICATION** | **DOSE** | **ROUTE** |  | **SELECT**  | **LAB REQUESTED** | **WHEN** | **FREQUENCY** |
|  | **BENADRYL** |  |  |  |  | **BMP** | **( ) PRIOR ( ) POST** |  |
|  | **ACETAMINOPHEN** |  |  |  |  | **CMP** | **( ) PRIOR ( ) POST** |  |
|  | **SOLUMEDROL** |  |  |  |  | **BUN/CREATININE** | **( ) PRIOR ( ) POST** |  |
|  | **OXYGEN** |  |  |  |  | **JCV ANTIBODY****(Patients taking Tysabri)** | **(X ) PRIOR ( ) POST** | **EVERY 6 MONTHS** |
|  | **FAMOTIDINE** |  |  |  |  | **CRP** | **( ) PRIOR ( ) POST** |  |
|  | **Other:** |  |  |  |  | **ESR** | **( ) PRIOR ( ) POST** |  |
|  | **Other:** |  |  |  |  | **Other:** |  |  |

**NOTES/INSTRUCTIONS/COMMENTS/SPECIFIC BRAND OR TITRATION ORDERS FOR IVIG:**

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**Physician’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Signature Must Be Clear and Legible*

**Co-signature (If Required) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Signature Must Be Clear and Legible*

**INTRAVENOUS IMMUNO GLOBULIN ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HT: \_\_\_\_\_\_\_\_\_\_ in. WT: \_\_\_\_\_\_\_\_ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Phone # \_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tax ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STATEMENT OF MEDICAL NECESSITY**

Primary Diagnosis: ICD 10 + Description \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERTINENT MEDICAL HISTORY**

Does patient have venous access? **YES NO If yes, what type MEDIPORT PIV PICC LINE OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRESCRIPTION ORDERS:**

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL

b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED PER STANDARD PHARMACY CONCENTRATIONS AND HOSPITAL POLICY

**C)** DOSES MAY BE ROUNDED TO NEAREST VIAL SIZE WITHIN 10% OF PERSCRIBED DOSE. WEIGHT BASED DOSING WILL REMAIN FOR DURATION OF ORDER UNLESS WEIGHT CHANGES +/- BY \_\_\_\_\_\_ %

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SELECT**  | **DOSE** | **ROUTE**  | **RATE** | **REPEAT EVERY** | **DURATION** |
|  | **\_\_\_\_\_\_\_\_ MG X \_\_\_\_\_\_ KG= \_\_\_\_\_\_\_\_\_\_\_\_MG** | **IV** | **TITRATE PER POLICY** |  |  |
|  |  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_MG** | **IV** | **TITRATE PER POLICY** |  |  |

**PREMEDS LABS**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SELECT**  | **MEDICATION** | **DOSE** | **ROUTE** |  | **SELECT**  | **LAB REQUESTED** | **WHEN** | **FREQUENCY** |
|  | **BENADRYL** |  |  |  |  | **BMP** | **( ) PRIOR ( ) POST** |  |
|  | **ACETAMINOPHEN** |  |  |  |  | **CMP** | **( ) PRIOR ( ) POST** |  |
|  | **SOLUMEDROL** |  |  |  |  | **BUN/CREATININE** | **( ) PRIOR ( ) POST** |  |
|  | **FAMOTIDINE** |  |  |  |  | **Other:** | **( ) PRIOR ( ) POST** |  |
|  | **Other:** |  |  |  |  | **Other:** | **( ) PRIOR ( ) POST** |  |

**NOTES/SPECIAL INSTRUCTIONS**

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**Physician’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Signature Must Be Clear and Legible*

**Co-signature (If Required) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Signature Must Be Clear and Legible*

**OSTEOPOROSIS ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HT: \_\_\_\_\_\_\_\_\_\_ in. WT: \_\_\_\_\_\_\_\_ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Phone # \_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tax ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STATEMENT OF MEDICAL NECESSITY**

Primary Diagnosis: (ICD-10 CODE + DESCRIPTION)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERTINENT MEDICAL HISTORY**

Does patient have venous access? **YES NO If yes, what type MEDIPORT PIV PICC LINE OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

a) ALL MEDIPORTS/IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL

**PRESCRIPTION ORDERS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SELECT**  | **MEDICATION** | **DOSE** | **ROUTE** | **FREQUENCY**  | **DURATION** |
|  | **RECLAST (ZOLEDRONIC ACID)**ADMINISTER OVER NO LESS THAN 15 MINUTES BUN, CREAT, AND CALCIUM LEVEL WITHIN 14 DAYS OF APPOINTMENT HOLD IF CALCIUM LEVELS < \_\_\_\_\_ or IONIZED CALCIUM LEVEL <\_\_\_\_\_\_\_ or IF CRCL < 35 ML/MIN | **5 Mg** | **IV** | **ONCE EVERY 12 MONTHS** | **1 Year** |
|  | **PROLIA (DENOSUMAB)**CALCIUM MUST BE CHECKED WITHIN 4 WEEKS OF THE APPOINTMENT. HOLD IF CALCIUM LEVELS < \_\_\_\_\_ or IONIZED CALCIUM LEVEL <\_\_\_\_\_\_\_ | **60 Mg** | **SC** | **ONCE EVERY 6 MONTHS** | **1 Year** |
|  | **EVINITY** | **210 Mg** | **SC** | **ONCE EVERY MONTH x 12**  | **1 Year** |

**SUPPORTING DOCUMENTATION FOR PATIENTS RECEIVING RECLAST, PROLIA, OR EVINITY:**

* **CALCIUM MUST BE CHECKED WITHIN 4 WEEKS OF THE APPOINTMENT**
* **BONE DENSITY / DEXA SCAN INDICATING OSTEOPOROSIS**
* **DOCUMENTATION OF PREVIOUS FRAGILITY FRACTURE FROM SITTING OR STANDING HEIGHT**
* **H+P OR OFFICE NOTES LISTING THE DIAGNOSIS OF OSTEOPOROSIS IN THE PATIENT RECORD DATED WITHIN 1 YEAR PRIOR TO APPOINTMENT**
* **PRIOR/CURRENT MEDICATIONS USED TO TREAT THE DIAGNOSIS OF OSTEOPOROSIS MUST BE DOCUMENTED IN PATIENT’S MEDICAL RECORD**

**(Examples: Oral calcium, Vitamin D, Bisphosphonates)**

**RECLAST, PROLIA, NOR EVINITY ARE INDICATED FOR THE TREATMENT OF PATIENTS WITH OSTEOPENIA**

**Physician’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Signature Must Be Clear and Legible*

**Co-signature (If Required) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Signature Must Be Clear and Legible*

**BONE MARROW STIMULATING AGENTS ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_\_ DOB :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HT: \_\_\_\_\_\_\_\_\_\_ in. WT: \_\_\_\_\_\_\_\_ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Phone # \_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tax ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STATEMENT OF MEDICAL NECESSITY** Primary Diagnosis: (ICD-10 Code plus Description)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRESCRIPTION ORDERS**

Collect CBC prior to each injection (s) and fax results to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hold injection if Hemaglobin is ≥ to \_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SELECT** | **MEDICATION** | **DOSE** | **ROUTE** | **FREQUENCY** | **DURATION** |
|  | **Aranesp** |  |  |  |  |
|  | **Neulasta** |  |  |  |  |
|  | **Neupogen** |  |  |  |  |
|  | **Procrit ESRD *(Patients on Dialysis)*** |  |  |  |  |
|  | **Procrit NON ESRD** |  |  |  |  |
|  | **Retacrit ESRD *(Patients on Dialysis)*** |  |  |  |  |
|  | **Retacrit NON ESRD** |  |  |  |  |
|  | **Other:** |  |  |  |  |

**NOTES:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Signature Must Be Clear and Legible*

**Co-signature (If Required) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Signature Must Be Clear and Legible*

**ASTHMA AGENTS**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HT: \_\_\_\_\_\_\_\_\_\_ in. WT: \_\_\_\_\_\_\_\_ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Phone # \_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tax ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STATEMENT OF MEDICAL NECESSITY**

Primary Diagnosis: (ICD-10 Code plus Description)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRESCRIPTION ORDERS**

1. WEIGHT BASED DOSING WILL REMAIN FOR DURATION OF ORDER UNLESS WEIGHT CHANGES +/- BY 10 %
2. Pretreatment Serum IgE (Xolair) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SELECT** | **MEDICATION** | **DOSE** | **ROUTE** | **FREQUENCY** | **DURATION** |
|  | **XOLAIR** | **\_\_\_\_ 150mg****\_\_\_\_ 225mg****\_\_\_\_ 300mg****\_\_\_\_ 375mg** | **SQ** | **Every \_\_\_\_\_\_\_\_\_ days**  |  |
|  | **FASENRA (LOADING DOSES)** | **30mg** | **SQ** | **Every 4 weeks for 3 doses, then every 8 weeks** |  |
|  | **FASENRA (MAINTANENCE DOSES)** | **30mg** | **SQ** | **Every 8 weeks** |  |

**PREMEDS LABS**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SELECT BELOW** | **MEDICATION** | **DOSE** | **ROUTE** |  | **SELECT BELOW** | **LAB REQUESTED** | **WHEN** | **FREQUENCY** |
|  | **NONE** | **NA** | **NA** |  |  | **NONE** | **NA** | **NA** |
|  | **BENADRYL** |  |  |  |  | **BMP** | **( ) PRIOR ( ) POST** |  |
|  | **ACETAMINOPHEN** |  |  |  |  | **CMP** | **( ) PRIOR ( ) POST** |  |
|  | **OXYGEN** |  |  |  |  | **BUN/CREATININE** | **( ) PRIOR ( ) POST** |  |
|  | **Other:** |  |  |  |  | **CRP:** | **( ) PRIOR ( ) POST** |  |
|  | **Other:** |  |  |  |  | **ESR:** | **( ) PRIOR ( ) POST** |  |
|  | **Other:** |  |  |  |  | **Other:** | **( ) PRIOR ( ) POST** |  |

**NOTES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Signature Must Be Clear and Legible*

**Co-signature (If Required) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Signature Must Be Clear and Legible*

**RHEUMATOLOGY ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_HT: \_\_\_\_\_\_\_\_\_\_\_\_\_ in WT: \_\_\_\_\_\_\_\_\_\_\_\_ kg

Sex :( ) Male ( ) Female Allergies: ( ) NKDA, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tax ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STATEMENT OF MEDICAL NECESSITY**

Primary Diagnosis: (ICD-10 Code plus Description) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERTINENT MEDICAL HISTORY**

Does patient have venous access? **YES NO If yes, what type MEDIPORT PIV PICC LINE OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1)TB test performed? 🞅 Yes 🞅 No Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***TB testing will be completed per ACR Guidelines and hospital policy.***

2) Patient diagnosed with Congestive Heart Failure? 🞅 Yes 🞅 No 3) Liver function test normal? 🞅 Yes 🞅 No 4) Hep-B antigen surface antibody test? 🞅 Yes 🞅 No Date: \_\_\_\_\_\_\_\_\_\_\_\_

4) Patient previously treated with any of the following: (please select) 🞅 Remicade 🞅 Inflectra 🞅 Simponi Aria 🞅 Benlysta 🞅 Rituxan 🞅 Orencia 🞅 Actemra 🞅 Stelara, Date: \_\_\_\_\_\_\_\_\_\_

**PRESCRIPTION ORDERS:**

**a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL**

**b) ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED PER STANDARD PHARMACY CONCENTRATIONS AND HOSPITAL POLICY**

**c) DOSES MAY BE ROUNDED TO NEAREST VIAL SIZE WITHIN 10% OF PERSCRIBED DOSE. WEIGHT BASED DOSING WILL REMAIN FOR DURATION OF ORDER UNLESS WEIGHT CHANGES +/- BY \_\_\_\_\_\_ %**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Select** | **MEDICATION** | **DOSE** | **ROUTE** | **FREQUENCY** | **DURATION** |
|  | **ACTEMRA** | **\_\_\_\_\_ MG / \_\_\_\_KG= \_\_\_\_\_ MG** |  | **EVERY \_\_\_\_\_ WEEKS** |  |
|  | **BENLYSTA LOADING DOSES** | **10 MG / \_\_\_\_\_\_KG= \_\_\_\_\_\_\_ MG** | **IV** | **0, 2, 4 WEEKS, THEN ONCE EVERY 4 WEEKS** |  |
|  | **BENLYSTA MAINTENANCE DOSES** | **10 MG / \_\_\_\_\_\_KG= \_\_\_\_\_\_\_ MG** | **IV** | **ONCE EVERY 4 WEEKS** |  |
|  | **BENLYSTA MAINTENANCE DOSES** | **200 mg** | **SC** | **ONCE WEEKLY** |  |
|  | **INFLECTRA LOADING DOSES** | **\_\_\_\_\_ MG / \_\_\_\_KG= \_\_\_\_\_ MG** | **IV** | **0, 2, 6 WEEKS, THEN ONCE EVERY WEEKS****RATE: RAPID or STANDARD**  |  |
|  | **INFLECTRA MAINTENANCE DOSES**  | **\_\_\_\_\_ MG / \_\_\_\_KG= \_\_\_\_\_ MG** | **IV** | **ONCE EVERY WEEKS****RATE: RAPID or STANDARD**  |  |
|  | **KRYSTEXXA** | **8 mg** | **IV** | **ONCE EVERY 2 WEEKS** |  |
|  | **ORENCIA (LOADING DOSES)** | **\_\_\_\_ mg** | **IV** | **0, 2, 4 WEEKS, THEN ONCE EVERY 4 WEEKS** |  |
|  | **ORENCIA MAINTENANCE DOSES** | **500 mg** | **IV** | **EVERY 4 WEEKS** |  |
|  | **ORENCIA MAINTENANCE DOSES** | **750 mg** | **IV** | **EVERY 4 WEEKS** |  |
|  | **ORENCIA MAINTENANCE DOSES** | **1000 mg** | **IV** | **EVERY 4 WEEKS** |  |
|  | **REMICADE LOADING DOSES** | **\_\_\_\_\_ MG / \_\_\_\_KG= \_\_\_\_\_ MG** | **IV** | **0, 2, 6 WEEKS, THEN ONCE EVERY WEEKS****RATE: RAPID or STANDARD**  |  |
|  | **REMICADE MAINTENANCE DOSES**  | **\_\_\_\_\_ MG / \_\_\_\_KG= \_\_\_\_\_ MG** | **IV** | **ONCE EVERY WEEKS****RATE: RAPID or STANDARD**  |  |
|  | **RITUXAN** | **\_\_\_\_\_ MG / \_\_\_\_KG= \_\_\_\_\_ MG** | **IV** | **EVERY \_\_\_\_\_ WEEKS** |  |
|  | **SIMPONI ARIA** | **\_\_\_\_\_ MG / \_\_\_\_KG= \_\_\_\_\_ MG** | **IV** | **EVERY \_\_\_\_\_ WEEKS** |  |
|  | **STELARA LOADING DOSES** | **45 Mg** | **SC** | **0, 4 WEEKS, THEN ONCE EVERY 12 WEEKS** |  |
|  | **STELARA MAINTENANCE DOSES** | **45 Mg** | **SC** | **ONCE EVERY 12 WEEKS** |  |
|  | **STELARA LOADING DOSES** | **90 Mg** | **SC** | **0, 4 WEEKS, THEN ONCE EVERY 12 WEEKS** |  |
|  | **STELARA MAINTENANCE DOSES** | **90 Mg** | **SC** | **ONCE EVERY 12 WEEKS** |  |

**PREMEDS LABS**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SELECT** | **MEDICATION** | **DOSE** | **ROUTE** |  | **SELECT**  | **LAB REQUESTED** | **WHEN** | **FREQUENCY** |
|  | **NONE** | **NA** | **NA** |  |  | **NONE** | **NA** | **NA** |
|  | **BENADRYL** |  |  |  |  | **BMP** |  |  |
|  | **ACETAMINOPHEN** |  |  |  |  | **CMP** |  |  |
|  | **OXYGEN** |  |  |  |  | **BUN/CREATININE** |  |  |
|  | **SOLU-MEDROL** |  |  |  |  | **CRP** |  |  |
|  | **ONDANSETRON** |  |  |  |  | **ESR** |  |  |
|  | **FAMOTIDINE** |  |  |  |  | **ALT** |  |  |
|  | **Other:** |  |  |  |  | **AST** |  |  |
|  | **Other:** |  |  |  |  | **LIVER PANEL** |  |  |
|  | **Other:** |  |  |  |  | **VECTRA** |  |  |
|  | **Other:** |  |  |  |  | **OTHER:** |  |  |

**Physician’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Signature Must Be Clear and Legible*

**Co-signature (If Required) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Signature Must Be Clear and Legible*

**IRON PRODUCTS ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HT: \_\_\_\_\_\_\_\_\_\_ in. WT: \_\_\_\_\_\_\_\_ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Phone # \_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tax ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STATEMENT OF MEDICAL NECESSITY**

Primary Diagnosis: (ICD-10 Code plus Description)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERTINENT MEDICAL HISTORY**

Does patient have venous access? **YES NO If yes, what type MEDIPORT PIV PICC LINE OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRESCRIPTION ORDERS**

1. ALL MEDIPORTS/IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL
2. ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED PER STANDARD PHARMACY CONCENTRATIONS AND HOSPITAL POLICY

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SELECT** | **MEDICATION** | **DOSE** | **ROUTE** | **FREQUENCY** | **DURATION** |
|  | **VENOFER** |  **\_\_\_\_\_ mg** | **IV** |  |  |
|  | **VENOFER** | **200 mg** | **IV** | **ONCE EVERY WEEK** | **5 Doses** |
|  | **FERRLECIT**  |  | **IV** |  |  |
|  | **OTHER:** |  |  |  |  |

**PREMEDS LABS**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SELECT BELOW** | **MEDICATION** | **DOSE** | **ROUTE** |  | **SELECT BELOW** | **LAB REQUESTED** | **WHEN** | **FREQUENCY** |
|  | **NONE** | **NA** | **NA** |  |  | **NONE** | **NA** | **NA** |
|  | **BENADRYL** | **50mg** | **IV** |  |  | **BMP** | **( ) PRIOR ( ) POST** |  |
|  | **ACETAMINOPHEN** |  |  |  |  | **CMP** | **( ) PRIOR ( ) POST** |  |
|  | **OXYGEN** |  |  |  |  | **BUN/CREATININE** | **( ) PRIOR ( ) POST** |  |
|  | **EPINEPHRINE** | **0.3mg / 0.3ml** | **IM** |  |  | **CRP:** | **( ) PRIOR ( ) POST** |  |
|  | **SOLU-MEDROL** | **125mg** | **IV** |  |  | **ESR:** | **( ) PRIOR ( ) POST** |  |
|  | **Other:** |  |  |  |  | **Other:** | **( ) PRIOR ( ) POST** |  |

**NOTES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Signature Must Be Clear and Legible*

**Co-signature (If Required) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Signature Must Be Clear and Legible*

**THERAPEUTIC PHLEBOTOMY ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HT: \_\_\_\_\_\_\_\_\_\_ in. WT: \_\_\_\_\_\_\_\_ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Phone # \_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tax ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STATEMENT OF MEDICAL NECESSITY**

Primary Diagnosis: (ICD 10 CODE + DESCRIPTION) Secondary Diagnosis: (ICD 10 CODE + DESCRIPTION)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRESCRIPTION ORDERS**

1. ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH HEPARIN OR SALINE PER HOSPITAL PROTOCOL PRN
2. 10ml NS Flush Syringe PRN

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **MLS TO REMOVE****+/- 50MLS** | **PARAMATERS** | **FREQUENCY** | **DURATION** |
| **Therapeutic Phlebotomy** |  | **HOLD IF****if ≤** |  **1 x only** **Weekly** **Monthly** **Other:** |  |

**LABS NOTES/INSTRUCTIONS/OTHER**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **SELECT BELOW** | **LAB REQUESTED** | **FREQUENCY** |
|  | **NONE** | **NA** |
|  | **CBC w/ Diff** | **PRIOR TO EACH PHLEBOTOMY** |
|  | **Hgb** | **PRIOR TO EACH PHLEBOTOMY** |
|  | **Hct** | **PRIOR TO EACH PHLEBOTOMY** |
|  | **BMP** |  |
|  | **CMP** |  |
|  | **BUN/CREATININE** |  |
|  | **ESR** |  |
|  | **CRP** |  |
|  | **CPK** |  |
|  | **Ferritin** |  |
|  | **Other:** |  |
|  | **Other:** |  |

**Physician’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Signature Must Be Clear and Legible*

**Co-signature (If Required) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Signature Must Be Clear and Legible*

**HEADACHE ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HT: \_\_\_\_\_\_\_\_\_\_ in. WT: \_\_\_\_\_\_\_\_ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Phone # \_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tax ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STATEMENT OF MEDICAL NECESSITY**

Primary Diagnosis: (ICD-10 Code plus Description)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERTINENT MEDICAL HISTORY**

Does patient have venous access? **YES NO If yes, what type MEDIPORT PIV PICC LINE OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRESCRIPTION ORDERS**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **SELECT** | **MEDICATION** | **DOSE** | **ROUTE** | **FREQUENCY** | **DURATION** |
|  | **BENADRYL** |  |  |  |  |
|  | **COMPAZINE** |  |  |  |  |
|  | **DEPAKOTE** |  |  |  |  |
|  | **DHE 45** |  |  |  |  |
|  | **DILANTIN** |  |  |  |  |
|  | **KEPPRA** |  |  |  |  |
|  | **KETOROLAC** |  |  |  |  |
|  | **METHYLPREDNISOLONE** |  |  |  |  |
|  | **METOCLOPRAMIDE** |  |  |  |  |
|  | **ORPHENADRINE** |  |  |  |  |
|  | **PROMETHAZINE** |  |  |  |  |
|  | **VYEPTI** | **100mg**  | **IV** | **Once Every 3 Months** |  |
|  | **0.9% NS** |  |  |  |  |

**PREMEDS LABS**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SELECT BELOW** | **MEDICATION** | **DOSE** | **ROUTE** |  | **SELECT BELOW** | **LAB REQUESTED** | **WHEN** | **FREQUENCY** |
|  | **NONE** | **NA** | **NA** |  |  | **NONE** | **NA** | **NA** |
|  | **BENADRYL** | **50mg** | **IV** |  |  | **BMP** | **( ) PRIOR ( ) POST** |  |
|  | **ACETAMINOPHEN** |  |  |  |  | **CMP** | **( ) PRIOR ( ) POST** |  |
|  | **OXYGEN** |  |  |  |  | **BUN/CREATININE** | **( ) PRIOR ( ) POST** |  |
|  | **ZOFRAN** |  | **IV** |  |  | **CRP:** | **( ) PRIOR ( ) POST** |  |
|  | **Other:** |  |  |  |  | **ESR:** | **( ) PRIOR ( ) POST** |  |
|  | **Other:** |  |  |  |  | **Other:** | **( ) PRIOR ( ) POST** |  |

**Physician’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Signature Must Be Clear and Legible*

**Co-signature (If Required) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Signature Must Be Clear and Legible*

**ANTIBIOTICS ORDER FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HT: \_\_\_\_\_\_\_\_\_\_ in. WT: \_\_\_\_\_\_\_\_ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Phone # \_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tax ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY DIAGNOSIS**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SECONDARY DIAGNOSIS**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does patient have venous access? \_\_\_YES \_\_\_NO If “YES”, what type? \_\_\_ MEDIPORT \_\_\_PIV \_\_\_PICC LINE \_\_\_MID LINE \_\_\_OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PICC LINE INSTRUCTIONS MUST BE SELECTED (Check the option**): \_\_\_\_ D/C PICC AFTER LAST DOSE \_\_\_PERFORM LINE CARE PER HOSPITAL PROTOCOL UNTIL

 LINE IS REMOVED

1. ALL MEDIPORTS/IV ACCESSES MAY BE FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL
2. HOSPITAL PHARMACY WILL FOLLOW AND ADJUST DOSING FOR VANCOMYCIN, GENTAMICIN, AND MAY INTERVENE PER HOSPITAL PROTOCOL FOR PATIENT SAFETY

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SELECT** | **DRUG** | **DOSE** | **ROUTE** | **REPEAT EVERY** | **DURATION** |  | **SELECT** | **DRUG** | **DOSE** | **ROUTE** | **REPEAT EVERY** | **DURATION** |
|   | Vancomycin | 500 mg | IV |   |   |  |   | Merrem (Meropenem) | 500 mg | ( ) IV  |   |   |
|   | Vancomycin | 750 mg | IV |   |   |  |   | Merrem (Meropenem) | 1000 mg | ( ) IV  |   |   |
|   | Vancomycin | 1000 mg | IV |   |   |  |   | Gentamicin (Garamycin) |  | ( ) IV  |   |   |
|   | Vancomycin | 1500 mg | IV |   |   |  |   | Levaquin (Levofloxacin) | 250 mg | IV |   |   |
|   | Vancomycin | 2000 mg | IV |   |   |  |   |  Levaquin (Levofloxacin) | 500 mg | IV |   |   |
|   | Rocephin (Ceftriaxone) | 250 mg | ( ) IV ( ) IM |   |   |  |   |  Levaquin (Levofloxacin) | 500 mg | IV |   |   |
|   | Rocephin (Ceftriaxone) | 500 mg | ( ) IV ( ) IM |   |   |  |   |  Levaquin (Levofloxacin) | 750 mg | IV |   |   |
|   | Rocephin (Ceftriaxone) | 750 mg | ( ) IV ( ) IM |   |   |  |   | Dalvance (Dalbavancin) | 1500 mg | IV | NA | X 1 Dose |
|   | Rocephin (Ceftriaxone) | 1000 mg | ( ) IV ( ) IM |   |   |  |   | Dalvance (Dalbavancin) | 1000 mg Day 1, 500mg Day 8 | IV |   |   |
|   | Rocephin (Ceftriaxone) | 2000 mg | ( ) IV ( ) IM |   |   |  |   | Orbactiv (Oritavancin) | 1200 mg | IV |   |   |
|  | Invanz (Ertapenem) | 500 mg | ( ) IV ( ) IM |   |   |  |  |  |  |  |   |   |
|  | Invanz (Ertapenem) | 1000 mg | ( ) IV ( ) IM |   |   |  |  |  |  |  |   |   |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **SELECT** | **LAB REQUESTED** | **WHEN** | **FREQUENCY** |  | **SELECT** | **LAB REQUESTED** | **WHEN** | **FREQUENCY** |
|  |   | **NONE** | NA | NA |  |   | **CK** | PRIOR ( ) POST ( ) |  |
|  |   | **BMP** | PRIOR ( ) POST ( ) |   |  |   | **UA** | PRIOR ( ) POST ( ) |   |
|  |   | **CMP** | PRIOR ( ) POST ( ) |   |  |   | **CBC:** | PRIOR ( ) POST ( ) |   |
|  |   | **BUN/CREATININE** | PRIOR ( ) POST ( ) |   |  |   | **Other:** | PRIOR ( ) POST ( ) |   |
|  |   | **CRP** | PRIOR ( ) POST ( ) |   |  |   | **Other:** | PRIOR ( ) POST ( ) |   |
|  |   | **ESR** | PRIOR ( ) POST ( ) |   |  |   | **Other:** | PRIOR ( ) POST ( ) |   |
|  |  | **ALT** | PRIOR ( ) |  |  |  | **Other:** |  |  |
|  |  | **VANCO TROUGH** |  |  |  |  | **Other**: |  |  |
|  |  | **GENT TROUGH** |  |  |  |  | **Other:** |  |  |

 **Physician’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Signature must be clear and legible with the time and date of signature for order to be processed*

**Co-Signature (If Required) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*\*Signature must be clear and legible with the time and date of signature for order to be processed*