

Name: _____
MRN: _____
DOB: _____

Today's Date _____ Time _____

Diagnosis: _____ Other: _____

Age: _____ Height (cm): _____ Weight (kg): _____ BSA (m²): _____

ALLERGIES/Sensitivities: NKDA or _____

Start Date (at least 1 wk from today): _____ **Urgent (Call Infusion Center)**

Treatment Department: EHW OP Infusion

Appointment Requests: Tolerance: Use default, for chronic treatments order valid for 1 year

Appointment Request – Infusion – 2 hours Every 28 days x 2 treatments

Treatment Conditions: Once on Day 1

Administer Treatment if:

Hepatitis B surface antigen and Hepatitis B core antibody NONREACTIVE (within 365 days)

Administer treatment if - Tuberculosis Test Negative (within 365 days)

NOTE: TESTING SHOULD NOT DELAY TREATMENT

Okay to treat. Include details here: _____

Labs:

Comprehensive Metabolic Panel

CBC with Diff

C-Reactive Protein

Sedimentation Rate

Hepatitis B surface antigen

Hepatitis B core antibody

Quantiferon-TB Gold Plus

T-Spot Tuberculosis Test

Pre-Medications: Order will be done as per appointment frequency

Acetaminophen tablet 650 mg, oral, Once

Diphenhydramine 25mg, once (choose one) tablet, Oral injection, IV

Famotidine 20 mg, once (choose one) tablet, Oral injection, IV

Hydrocortisone sodium succinate injection 100 mg, intravenous, once

Supportive Care: Order will be done as per appointment frequency

sodium chloride prime bag 250 ml
250 ml, intravenous, at 0-999, PRN as needed, Prime Bag

All information provided on this form & calculations have been independently confirmed & recalculated as indicated by signature(s) below

Licensed Medical Professional

Print Name: _____

Signature _____

Date _____

Contact # _____

Attending Physician

Print Name: _____

Signature _____

Date _____

Contact # _____

Name: _____
MRN: _____
DOB: _____

Transfusion:

Order will be done as per appointment frequency

Golimumab (Simponi Aria) 2 mg/kg, _____ mg in in NS 100 mL over 30 min
Infuse over 30 minutes using low-protein binding 0.2 micron filter.

Emergency Medications

Order will be done as per appointment frequency

Hypersensitivity reaction protocol

Protocol Document: <https://emory.ellucid.com/documents/view/15307/15641>

All information provided on this form & calculations have been independently confirmed & recalculated as indicated by signature(s) below

Licensed Medical Professional

Print Name: _____
Signature _____
Date _____
Contact # _____

Attending Physician

Print Name: _____
Signature _____
Date _____
Contact # _____