

[Place patient sticker here]

Name: \_\_\_\_\_  
MRN: \_\_\_\_\_  
DOB: \_\_\_\_\_

Today's Date \_\_\_\_\_ Time \_\_\_\_\_

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

Age: \_\_\_\_\_ Height (cm): \_\_\_\_\_ Weight (kg): \_\_\_\_\_ BSA (m<sup>2</sup>): \_\_\_\_\_

**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 56 days x 3 treatments

**Treatment Conditions:**  Once on Day 1

Okay to treat. Include details here: \_\_\_\_\_

**Labs:** Lab (if selected) will be done as per appointment frequency selected above (unless specified)

- Comprehensive Metabolic Panel
- CBC with Diff
- C-Reactive Protein
- Sedimentation Rate

**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

**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 # \_\_\_\_\_