EMORY HEALTHCARE

PHYSICIAN'S ORDERS

Therapy: Romosozumab Monthly

[Place patient sticker here]

Name: _____
MRN: _____
DOB: _____

Today's Date _____ Time _____

Diagnosis: _____ ☐ Other: _____

Age: _____ Height (cm): _____ Weight (kg): _____ BSA (m^2): _____

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 Every 28 days

Nursing Orders: ☒ *Order will be done as per appointment frequency*

☒ Notify MD/ Provider if: Temp >38.0 C, SBP <100 or >170, DBP <50 or >110, HR <50 or >110

☒ Observation/Monitoring:
Observation time in addition to infusion duration (min): 15
When: Post-dose

Medications: ☒ *Order will be done as per appointment frequency*

Romosozumab 210 mg, subcutaneous

☒
- Two consecutive 105 mg injections. Rotate injection sites between upper arm, upper thigh and abdomen.
- Remove from fridge and allow to sit at room temperature for 30 minutes prior to administering.

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		**Attending Physician**	
Print Name:		Print Name:	
Signature		Signature	
Date		Date	
Contact #		Contact #	