EMORY HEALTHCARE

PHYSICIAN'S ORDERS

Therapy Order Form for _____

[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 - _____ hours Every _____ days

To help calculate: 60 min drug prep time + drug infusion time + observation time if needed

Treatment Conditions (Administer Treatment If): ☐ 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)*

☐ CBC & Diff	☐ Once on Day 1
☐ Comprehensive Metabolic Panel	☐ Once on Day 1
☐ Basic Metabolic Panel	☐ Once on Day 1
☐ _____	☐ _____

Provider Communication: ☒ *Order will be done as per appointment frequency*

☐ _____

☐ _____

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

☐ _____

_____

☐ _____

_____

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 #	

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[Place patient sticker here]

Name: _____
MRN: _____
DOB: _____

Pre-Medications:

☒ *Order will be done as per appointment frequency*
☒ *Instructions: Give at least 30 minutes prior to infusion*

☐ Acetaminophen tablet 650 mg, oral, Once

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

☐ Loratadine tablet 10 mg, PO, Once

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

☐ Ondansetron 4mg, once (choose one) ☐ tablet, Oral ☐ injection, IV

☐ Hydrocortisone sodium succinate injection 100 mg, intravenous, once

☐ Montelukast tablet, 10 mg, oral

☐ MethylPREDNISolone sodium succinate (PF) injection, 40 mg intravenous, once

Supportive Care:

☒ *Order will be done as per appointment frequency*

☒ Sodium chloride 0.9% prime bag 250 ml
250 ml, intravenous, at 0-999, PRN as needed, Prime Bag

Medications:

☒ *Order will be done as per appointment frequency*

Please include drug name, route of administration, infusion time, FREQUENCY and duration of doses

☒ _____

_____

_____

_____

☐ _____

_____

_____

_____

Emergency Medications

☒ *Order will be done as per appointment frequency*

☒ Hypersensitivity reaction protocol
Protocol Document: https://emory.ellucid.com/documents/view/15307/15641

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Licensed Medical Professional		**Attending Physician**	
Print Name:		Print Name:	
Signature		Signature	
Date		Date	
Contact #		Contact #	