

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: Use default, for chronic treatments order valid for 1 year

Tolerances: Schedule appointment at most 5 days before or at most 5 days after

Appointment Request – Infusion – 4 hours Every _____ days

Provider to select for IVIG doses less than or equal to 50 grams

Appointment Request – Infusion – 6 hours Every _____ days

Provider to select for IVIG doses greater than or equal to 50 grams

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

CBC Once

Comprehensive Metabolic Panel Once

Nursing Orders: Order will be done as per appointment frequency

Monitoring Communication

Monitor vital signs prior to start of infusion and at the end of infusion

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

Acetaminophen tablet 650 mg, oral, Once

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

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

Methylprednisolone sodium succinate (PF) 100 mg intravenous, IV once

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

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: _____

Pre-Hydration (choose one)

Order will be done as per appointment frequency

- sodium chloride 0.9 % bolus 250 mL
250 mL, intravenous, Administer over: 0.5 Hours
- sodium chloride 0.9 % bolus 500 mL
500 mL, intravenous, Administer over:0.5 Hours

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

Provider Communication (choose one):

Order will be done as per appointment frequency

- Pharmacy to adjust dose based on ideal body weight.
- IVIG: Use lesser of Ideal Body Weight or Total Body Weight
Keep dose the same for duration of plan
- Pharmacy **DO NOT** adjust dose based on ideal body weight.
Keep dose the same for duration of plan

Medication:

Order will be done as per appointment frequency

Immune globulin 10% infusion.

- Daily: **Immune globulin 10% infusion** (0.4 g/kg) ____g IV daily
On Days 1-5 or Days _____
- Daily: **Immune globulin 10% infusion** (1 g/kg) ____ g IV daily
On Days 1-2 or Days _____
- Monthly: **Immune globulin 10% infusion** (choose one) (0.4 g/kg) (0.6 g/kg) (1 g/kg)
____g IV daily on Day 1 every month or _____
- Every ____ weeks: **Immune globulin 10% infusion** (choose one) (0.4 g/kg) (0.6 g/kg) (1 g/kg)
____ g IV daily on Day 1 every 2 3 4 5 6 7 8 ____ weeks

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: _____
 Signature _____
 Date _____
 Contact # _____

Print Name: _____
 Signature _____
 Date _____
 Contact # _____