

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES ACTH STIMILIATION TEST ORDER FORM

STA	TR	EFE	ERR	ΑL

	INFORMATION		MULATION 1EST ORI		MI DO	an.
					MI DC	
н:	kg Sex: L	_				
Physician					Contact Phone #	
NPI #:		Tax ID#:			Fax #:	
	ENT OF MEDICAL NECESSITY					
Primary D	Diagnosis: (ICD 10 CODE + DESCRIPT	TION)	Secondary Diagno	osis: (ICD 10 CODE	+ DESCRIPTION)	
	ient have venous access?	☐ NO If yes, what typ	e	□ PIV □ I	PICC LINE OTHER:	
PRESCR	IPTION ORDERS					
a)	ALL MEDIPORTS / IV ACCESSES	WILL BE FLUSHED WITH HEPA	RIN OR SALINE PER I	HOSPITAL POLICY	PRN	
SELECT	MEDICATION	DOSE	ROL	ITE	FREQUENCY	DURATION
	COSYNTROPIN 250 MCG/2 mL (NS		IV Push ove		ONCE	1
<u> </u>						
LABS			NOTES	S/INSTRUCTIONS/C	OTHER	
SELECT X	LAB REQUESTED ACTH LEVEL	FREQUENCY PRIOR				
X	CORTISOL LEVEL	PRIOR AND REPEAT 30 +	60			
	Other:	MINUTES POST INFUSION	<u> </u>			
	Other:					
	Other:					
	Other:					
1)	Vital signs will be measured prior SBP > 180, DBP > 110, or pulse > Flush line with 10 mL 0.9% NS the	120	pletion of test, and wit	th any clinical chan	ges that occur during the test. Notify ph	ysician if
*Signatur Cosignat	n's Signature re Must Be Clear and Legible ture (If Required)_ re Must Be Clear and Legible			_Time	Date Date	
	Fax completed form, supporting	ng documentation, faceshee	et, and insurance ca	rds to the Outpa	tient Infusion Center at 580-531-47	79 .



80-531-4779
SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
ANTIBIOTICS ORDER FORM

STAT	RFF	FRR	AL

	<u> INFORMATION</u>														
	in WT:	ka C	Sov : Mala E	omalo All		irst Name: NKDA,									
н:	IN WI:	кд S	bex : Li Male Li F	emaie Ali	ergies:	□ NKDA,									_
Physicia	n Name				C	ontact Name			(Contact Phone	#				
															_
RIMARY D	OIAGNOSIS:					SEC	CON	IDARY DIAG	iNOSIS:						
				-		☐ MEDIPORT		_	_						
a) . b) .	ALL MEDIPORTS/IV 500 mL BAG OF 0.9%	ACCESSES MA 6 NS MAY BE I	AY BE FLUSHED WIT HUNG AT KVO RATE	H SALINE OF	HEPAF	C PICC AFTER LAS	OLIC'	Y					NTIL LI	NE IS	REMOVED
·		CY WILL FOLL		REPE/	١T	MYCIN, GENTAMICII	N, AN		RVENE PER HOSPI	TAL POLICY FO	R PATIE	ENT SAFETY	REPE		
SELECT	DRUG	DOSE	ROUTE	EVER	Y	DURATION		SELECT	DRUG Invanz	DOSE		ROUTE	EVE	₹Y	DURATIO
	Vancomycin	500 mg	IV						(Ertapenem)	1000 mg					
	Vancomycin	750 mg	IV						Merrem (Meropenem)	500 mg		IV			
	Vancomycin	1000 mg	IV						Merrem (Meropenem)	1000 mg		IV			
	Vancomycin	1500 ma	IV						Gentamicin (Garamycin)			IV			
									Gentamicin	7					
	Vancomycin	1750 mg	IV						(Garamycin) Levaquin	7mg/kg		IV		-	
	Vancomycin Rocephin	2000 mg	IV						(Levofloxacin) Levaquin	250 mg		IV		\dashv	
	(Ceftriaxone) Rocephin	250 mg							(Levofloxacin) Levaguin	500 mg		IV		_	
	(Ceftriaxone)	500 mg	□∨□м						(Levofloxacin)	500 mg		IV			
	Rocephin (Ceftriaxone)	750 mg	□ IV □ IM						Levaquin (Levofloxacin)	750 mg		IV			
	Rocephin (Ceftriaxone)	1000 mg	□ Ⅳ □ ІМ						Dalvance (Dalbavancin)	1500 mg		IV	NA		X 1 Dose
	Rocephin (Ceftriaxone)	2000 mg	□∨□м						Dalvance (Dalbavancin)	1000 mg Day 500mg Day 8		IV			
	Invanz (Ertapenem)	500 mg	□ IV □ IM						Orbactiv (Oritavancin)	1200 mg		IV			
							1		(Ontavarion)	1200 Hig		IV			
	DICATION (not li								l						
SELECT	·	IESTED	WHEN		FR	EQUENCY		SELECT		UESTED		WHEN PRIOR POS		FREG	UENCY
	NONE BMP		NA PRIOR	POST		NA			CK UA			PRIOR POS			
	CMP		□ PRIOR □						Other:			PRIOR D POS			
	BUN/CREATIN	NINE	□ PRIOR □						Other:			PRIOR D POS			
	CRP		☐ PRIOR ☐	POST					Other:			PRIOR D POS	ST		
	ESR		☐ PRIOR ☐	POST					Other:			PRIOR D POS	ST		
	ALT		PRIOR						Other:						
	VANCO TROL	JGH							Other:						
	GENT TROUG	iH .							Other:						
NOT	ES:														
	sician's Signatur						т	ime		Date					
	nature must be clear	Ū								_					
	Signature (If Requature must be clear						1	Time		Date					
	Fax comr	oleted form	supporting doc	umentatio	n fac	esheet and insi	ıran	nce cards to	o the Outnatie	nt Infusion C	enter	at 580-531-	4779		



SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES ASTHMA AGENTS

STAT	REFERRAL

							'''' 501	·
· ·			rgies: 🗀	NKDA				
· ·			Contact N	Mamo		Con	staat Phono #	
STATEMENT OF MEDICAL NECESSITY Primary Diagnosis: (ICD-10 Code plus Descripti	ion)							
Date of Diagnosis:								
PRESCRIPTION ORDERS a) WEIGHT BASED DOSING WILL R b) Pretreatment Serum IgE (Xolair)				UNLES	S WEIGHT	CHANGES +/- BY 10 %		
ECT MEDICATION		DOSE	RO	UTE		FREQUEN	CY	DURATIO
] XOLAIR		☐ 150 mg	g					
		☐ 225 m	g	SQ Every days				
		300 m						
7 FASENRA (LOADING DOSE	FASENRA (LOADING DOSES)		S	SQ.		Every 4 weeks for 3 doses,	then every 8 weeks	
T FASENRA (MAINTENANCE DO	SES)	30 mg	S	SQ.		Every 8 wee	eks	
NUCALA		100 MG	S	Q		Every 4 wee	eks	
TEZSPIRE		210 mg	S	SQ.		Every 4 wee	eks	
PREMEDS		I.	I		LABS			ı
ECT MEDICATION		DOSE	ROUTE] [SELECT	LAB REQUESTED	WHEN	FREQUE
NONE		NA	NA			NONE	NA	NA
BENADRYL						ВМР	☐ PRIOR ☐ POST	
ACETAMINOPHEN						СМР	☐ PRIOR ☐ POST	
OXYGEN						BUN/CREATININE	☐ PRIOR ☐ POST	
Other:						CRP:	☐ PRIOR ☐ POST	
Other:						ESR:	☐ PRIOR ☐ POST	
Other:						Other:	☐ PRIOR ☐ POST	
NOTES/SPECIAL INSTRUCTIONS:								
Physician's Signature Signature Must Be Clear and Legible						_Time	Date	
Cosignature (If Required) Signature Must Be Clear and Legible						_Time	Date	



SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES BLOOD PRODUCT TRANSFUSION ORDER FORM

STAT	REF	ERR	AL

	NT INFORMATION ame:				First Namo	·-			MI	DOB:
н:	in WT:	kg Sex: ∟	J Male LJ Fe	emale Alle	rgies: 🔲 ini	KDA,				
Physici	an Name				Contact Nar	me		Cont	act Phone #	
NPI #:_				Tax ID#:_				Fax #:		
	MENT OF MEDICAL NECE									
Primar	/ Diagnosis: (ICD 10 CODE	+ DESCRIPT	ΓΙΟΝ)		S	econdary Diagn	osis: (ICD 10) CODE + DESCRIF	PTION)	
	NENT MEDICAL HISTORY					_				
Does p	atient have venous access?	☐ YES	□ №	If yes, wh	at type	MEDIPORT	☐ PIV	☐ PICC LINE	☐ OTHER:	
•	ne patient incontinent? C			•	•					
	the patient taken Darzale	,	•							
	type and cross been drawn? Center on arrival.	O Yes	O No If yes	, date and tin	ne	If no, pat	ent to go to	hospital lab on	date/time OR	to be drawn at
	S:									
a b c	500 mL BAG OF 0.9% NS TUBING WILL BE FLUSHI H+H MUST BE COMPLET	MAY BE HUN ED WITH 0.9% ED WITHIN C	IG AT KVO RATE 6 NS UNTIL TUB	E ING IS PINK T	INGED OR CL	_EAR		POLICY PRN		
TYPE, CROSSMATCH, AND TRANSFUSE: ELECT # of UNITS PRODUCT							LABS SELECT	LAB REQUESTE	:D	WHEN
		FRESH FI	ROZEN PLASI	MA				NONE		NA
		LEUKO R	EDUCED PRB	Cs				ВМР		☐ PRIOR ☐ POST
		LEUKO R	EDUCED IRRA	ADIATED PR	RBCs			CMP		☐ PRIOR ☐ POST
		LEUKO R	EDUCED PLA	TELETS				CBC w/ DIFF		☐ PRIOR ☐ POST
		LEUKO R	EDUCED IRRA	ADIATED PL	ATELETS			H+H:		☐ PRIOR ☐ POST
		PLATELE	TS TYPE SPE	CIFIC? O	Yes OR C	O No		T+C:		☐ PRIOR ☐ POST
		Other:						Other:		☐ PRIOR ☐ POST
PREMI							NOTES	/INSTRUCTIONS/C	OMMENTS	
LECT	MEDICATION		DOSE NA	ROUTE	NA NA	UENCY				
	BENADRYL		INA.	l IVA	INA .					
	ACETAMINOPHEN			1						
<u> </u>	OXYGEN									
	LASIX									
	Other:									
DIETA	RY RESTRICTIONS (If none	e, please inc	licate):							
Physic *Signal	ian's Signature ture Must Be Clear and Legib	ole					Time		Date	_
							Time		Data	
*Signat	nature (If Required) ture Must Be Clear and Legit						_ 11111 e		Date	_
	Fax completed form	, supportir	ng document	tation, face	sheet, and	l insurance ca	rds to the	Outpatient Infus	ion Center at 580-53	1-4779.



SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES BONE MARROW STIMULATING AGENTS ORDER FORM

STAT	REF	ERR	AL

	FORMATION .	First Name		M.	II DOR-			
	in WT:kg Sex:							
1	III WTkg Sex. 🗖 Male 🗖 Female	e Allergies. NNDA,						
			Contact Name Contact Phone #					
PI #:	Т	ax ID#:	Fa	x #:				
<u>TATEMENT</u>	OF MEDICAL NECESSITY Primary Diagnosis: (ICD	10 Code plus Description)						
ate of Diagn	nosis:							
RESCRIPTI	ION ORDERS							
ollect CBC p	prior to each injection (s) and fax results to Infusion Ce	<u>nter</u>						
old erythrop	ocietin injections if Hemoglobin is ≥ to <u>12 g/dL</u>							
SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION			
	Aranesp	DOSE	ROUTE	FREQUENCT	DURATION			
_ _	Neulasta							
Ц	Neupogen (Granix Substitute)							
	Procrit ESRD (Patients on Dialysis)							
П	Procrit NON ESRD							
	Retacrit ESRD (Patients on Dialysis)							
<u> </u>	Retacrit NON ESRD							
ᆜ	Other:							
	Guler.							
OTES/SPE	CIAL INSTRUCTIONS:							
nysician's S	Signatureust Be Clear and Legible		Time	Date				
Signature M	Signature ust Be Clear and Legible (If Required)		Time	Date				



Phone: 580-531-4892 Fax: 580-531-4779

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES GASTROENTEROLOGY ORDER FORM

S	ΤΔΤ	RI	FFF	RR	ΔΙ

PATIE	ENT INFORMATION			GASTROEN	TEROLOG	SY ORDER F	ORM		
	Name:			First Na	me:			MI DOB:_	
HT: _	in WT: kg	Sex: Ma	le 🔲 Female	Allergies:	NKDA, _				
——————————————————————————————————————	cian Name			Contact N	Name		Contact	Phone #	
	:								
Prima PERT Does	TEMENT OF MEDICAL NECESSION DIAGNOSIS: ICD-10 Code plus DETINENT MEDICAL HISTORY patient have venous access?	Description:	□ NO If yes	, what type	☐ MEDI	PORT [] PIV PICC LINE	□ OTHER:	
1) TB	test performed? O Yes O No D)ate:	Resu	ults,					
4) Pat 5) He PRES	tient diagnosed with Congestive H tient previously treated with Entyvi p-B antigen surface antibody test? SCRIPTION ORDERS: a) ALL MEDIPORTS / IV ACCES: b) 500 mL BAG OF 0.9% NS MA' c) ALL PRODUCTS WILL BE PR	io OR Remicad ? O Yes O No SES WILL BE FL Y BE HUNG AT F	le OR Simponi A Date: USHED WITH SAL (VO RATE	ria? O Yes O	No Please	e select: O E	intyvio O Remicade O Simpon	i Aria Date:	
SELECT	DOSING OPTIONS	3		DOSE		ROUTE	FREQUENCY (PC	OPULATE BELOW)	DURATION
	ENTYVIO (LOADING DOSES)		300 mg	2002		IV	0, 2, 6 WEEKS, THEN ONCE		- Boild Milon
	ENTYVIO (MAINTENANCE DO	OSE)	300 mg			IV	ONCE EVERY 8 WEEKS		
	RENFLEXIS (LOADING DOSE	:S)	mg / kg			IV	0, 2, 6 WEEKS, THEN ONCE		
	RENFLEXIS (MAINTENANCE	DOSES)	mg / kg			IV	ONCE EVERY WEE	EKS	
	OTHER:			mg / kg		IV	ONCE EVERY WEE	EKS	
PREM	MEDS					LABS			
SELECT	MEDICATION	DOSE	ROUTE	SELECT			AB REQUESTED	WHEN	FREQUENCY
	NONE	NA	NA		NONE			NA	NA
	BENADRYL				BMP			☐ PRIOR ☐ POST	
	ACETAMINOPHEN				CMP			☐ PRIOR ☐ POST	
	OXYGEN					REATININE		☐ PRIOR ☐ POST	
	SOLU-MEDROL				CRP			☐ PRIOR ☐ POST	
	Other:				ESR			☐ PRIOR ☐ POST	
	Other:				ALT			☐ PRIOR ☐ POST	
	Other:				AST			☐ PRIOR ☐ POST	
	Other:				LIVER	PANEL		☐ PRIOR ☐ POST	
	Other:				VECTR	A		☐ PRIOR ☐ POST	
	Other:				OTHER	₹:		☐ PRIOR ☐ POST	
	ES/INSTRUCTIONS/COMMENTS					Ti		Date	
	ician's Signature ature Must Be Clear and Legible					Ti	me	_ Date	
Cosig	gnature (If Required) ature Must Be Clear and Legible					Tiı	me	Date	
	Fax completed form, su	upporting do	cumentation,	facesheet, ar	nd insura	ance cards	to the Outpatient Infusion	Center at 580-531-4779	



SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES GENERAL IV ORDER FORM

STAT	REFI	ERRAL

IT:	in WT:kg Se	x: LI Male LI	Female Allergies:	NKDA,		
-					Contact Phone # _	
NPI #:			Tax ID#:		Fax #:	
	EMENT OF MEDICAL NECESSITY					
Primai	ry Diagnosis: (ICD 10 CODE + DES	CRIPTION)		Secondary Diagnosis: (ICI	D 10 CODE + DESCRIPTION)	
)nes i	patient have venous access?	YES 🗆 N	O If wes what type	☐ MEDIPORT ☐ P	IV DECLINE DOTHE	 R:
	CRIPTION ORDERS		o ii yee, what type		— 1100 EINE — — 0111E	
	a) ALL MEDIPORTS / IV ACCESSE:	O WILL BE ELLIQUE	D WITH HEDADIN OD CAL	INE DED HOSDITAL DOLLOV DE	DNI	
	a) ALL MEDIPORTS / IV ACCESSE;b) 500 mL BAG OF 0.9% NS MAY B			INE PER HOSPITAL POLICT PR	CIV .	
	PLEASE SELECT FROM BELOW					
			eks per hospital policy.			
	Perform IV site care p	er hospital policy				
NOTE	: For patients with central venous	access, please	select: D/C AFTER	R LAST DOSE		
		· ·				
	DRUG 1	<u> </u>	DOSE	ROUTE	FREQUENCY	DURATION
	DRUG 2		DOSE	ROUTE	FREQUENCY	DURATION
					<u> </u>	
	DRUG 3		DOSE	ROUTE	FREQUENCY	DURATION
	DRUG 3		DOSE	ROUTE	FREQUENCT	DURATION
	DRUG 4		DOSE	ROUTE	FREQUENCY	DURATION
LABS				NOTES/INSTR	UCTIONS/OTHER	
ECT	LAB REQUESTED		FREQUENCY			
]	NONE	NA				
]	CBC w/ Diff					
]	ВМР					
]	СМР					
<u>-</u>]	BUN/CREATININE					
	ESR					
<u>-</u>]	CRP					
	СРК					
<u>]</u>	Other:					
<u> </u>	Other:					
]	Julei.					
Physic	cian's Signature			Time_	Date	
*Signa	ature Must Be Clear and Legible					
Cosig	nature (If Required) ature Must Be Clear and Legible			Time_	Date	
	nure iviusi de Cieai aliù Legible					



SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES $\frac{\text{HEADACHE ORDER FORM}}{\text{MEDICAL CENTER INFUSION SERVICES}}$

STA [*]	T REF	ERR	AL

	IT INFORMATION me:			First Name:				MI DO	nR∙	
HI:	n W1:kg Sex: LI Mai	e ப	Female Allerg	jies: 🔲 NK	DA,					
Physicia	an Name			Contact Name	e		Contac	t Phone #		
NPI #:_			Tax ID#:				Fax #:			
	MENT OF MEDICAL NECESSITY Diagnosis: (ICD-10 Code plus Description)									
						Date of Diagnos	sis:			
								-		
	NENT MEDICAL HISTORY atient have venous access? YES	٦,,,	lf.voa vuhat	D	MED	NDORT	LDIV DIRECTINE	П отигр.		
				туре ш	MED	JIPORI L	I PIV	U OTHER:		
a)) 500 mL BAG OF 0.9% NS MAY BE HUNG AT I	(VU KA	.IE							
PRESC	RIPTION ORDERS									
ELECT	MEDICATION		DOSE	R	OUT	ГЕ	FRE	QUENCY		DURATION
	BENADRYL									
	COMPAZINE									
	DEPACON									
	DHE 45									
	DILANTIN									
	KEPPRA									
П	KETOROLAC									
	METHYLPREDNISOLONE									
	METOCLOPRAMIDE									
	ORPHENADRINE									
	PROMETHAZINE									
	VYEPTI		100 mg		IV		Once Ev	ery 3 Months		
	0.9% NS									
PREME	EDS MEDICATION		DOSE	ROUTE	1	LABS SELECT	LAB REQUESTED	WHEN	FR	REQUENCY
	NONE	NA		NA			NONE	NA	NA	
	BENADRYL			IV			ВМР	☐ PRIOR ☐ POST		
	ACETAMINOPHEN						CMP	☐ PRIOR ☐ POST		
	OXYGEN						BUN/CREATININE	☐ PRIOR ☐ POST		
	ZOFRAN			IV			CRP:	☐ PRIOR ☐ POST		
	Other:						ESR:	☐ PRIOR ☐ POST		
	Other:						Other:	□ PRIOR □ POST		
_]		1			
Physic	ian's Signature					Tim	10	Date		
*Signat	ure Must Be Clear and Legible									
	ature (If Required)					Tim	ne	_ Date		
"Signat	ure Must Be Clear and Legible									
	Fax completed form, supporting do	cume	ntation, faces	heet, and in	ารเม	rance cards	to the Outpatient Infusio	n Center at 580-531-47	79	



STAT	REFERRAL

	T INFORMATION								
Last Na	me:	First	: Name:			MI DOB:			
HT:	in WT:kg Sex:	Male Female Allergies:	□ NKDA, _						
-	n Name								
NPI #:_		Tax ID#:			Fax #:				
	MENT OF MEDICAL NECESSITY								
Primary	Diagnosis: (ICD 10 CODE)				Date of Diagnosis:				
PERTIN	ENT MEDICAL HISTORY								
Does pa	tient have venous access?	☐ NO If yes, what type	e 🗆 MED	IPORT PIV	☐ PICC LINE ☐ OTH	ER:			
a)	ALL MEDIPORTS/IV ACCESS WILL	BE ACCESSED AND FLUSHED	WITH SALIN	NE OR HEPARIN PER	HOSPITAL POLICY				
PRESC	RIPTION ORDERS FOR HYDRATION	Select the fluid requested	I AND the co	rresponding rate bel	ow				
1.)	☐ NORMAL SALINE		2.)	LACTATED RING	ERS				
☐ 50¢) mL, IV x		500 mL	., IV x					
	00 mL (1 Liter), IV x		<u> </u>	iiL (1 Liter), IV X					
2 0	00 mL (2 Liters), IV x		2000 n	nL (2 Liters), IV x					
RATE			RATE						
□во	LUS - GIVEN OVER 1 HOUR		☐ BOLUS - GIVEN OVER 1 HOUR						
Оν	er 2 hours @ mL/hour		Over 2 hours @mL/hour						
Оν	er 4 hours @ mL/hour		Over 4 hours @mL/hour						
Otl	ner: mL/hour		Oth	er:	mL/hour				
o	MEQ K+ OMG MAG C	Lidocaine 1% 2 mL	O OTHER:_		RATE MAY BE A	DJUSTED PER HOSPITAL POLICY			
(K+ ma	rate of 10mEq/hr)								
OTHER	(PLEASE SPECIFY DRUG, RATE, FRE	EQUENCY, AND DURATION BEL	LOW:						
LABS:	LAB REQUESTED	FREQUENCY		NOTES/INSTRUCT	IONS/COMMENTS				
	NONE	NONE							
	CBC w/ Diff	☐ PRIOR ☐ POST							
	ВМР	☐ PRIOR ☐ POST							
	CMP	☐ PRIOR ☐ POST							
	BUN/CREATININE								
	Other:	☐ PRIOR ☐ POST							
		☐ PRIOR ☐ POST							
DL				-	- .				
	an's Signature ire Must Be Clear and Legible			I ime	Date				
-	ature (If Required)			Time	Nate				
	re Must Be Clear and Legible				Date				
	Fax completed form, supporting	g documentation, facesheet	t, and insur	ance cards to the		at 580-531-4779.			



SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES INTRAVENOUS IMMUNE GLOBULIN ORDER FORM

STAT	REFERRAL

		INTRAVENO	US IIVIIVIUI	IE GLOBULII	ONDER FORIN				
	ENT INFORMATION Name:		First Name:				MI	DOB:	
	in WT:kg Sex:								
	cian Name:								
	EMENT OF MEDICAL NECESSITY								
Prima	ary Diagnosis: ICD 10 + Description:					Date	of Diagnosis:		
PERT	INENT MEDICAL HISTORY								
Does	patient have venous access?	NO If yes, what	type 🗆	MEDIPORT	☐ PIV ☐ PI	CC LINE	OTHER:		
PRES	SCRIPTION ORDERS:								
	a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUS b) ALL PRODUCTS WILL BE PREPARED AND ADM c) 500 mL BAG OF 0.9% NS MAY BE HUNG AT KV	MINISTERED FOLLOWI			DLICY				
SELECT	DOSE		ROUTE		RATE	RE	PEAT EVERY		DURATION
П	mg / kg		IV	TITRATE	PER POLICY				
	IIIg / kg								
	Flat Dose:gm		IV	TITRATE	PER POLICY				
	MEDS			LABS			<u>, </u>		
SELECT	MEDICATION BENADRYL	DOSE	ROUTE	SELECT	LAB REQUES BMP	STED	WHEN		FREQUENCY
	ACETAMINOPHEN				CMP		PRIOR	POST	
							☐ PRIOR ☐	POST	
	SOLUMEDROL				BUN/CREATININE		☐ PRIOR ☐	POST	
	FAMOTIDINE				Other:		☐ PRIOR ☐	POST	
	Other:				Other:		☐ PRIOR ☐	POST	
Phys	SICIAN'S SIGNATURE				Time_		Da	ate	
	markens (If Demoise II)				Time		Da	ıte	
*Sign	ature Must Be Clear and Legible				•				
	Fax completed form, supporting docu	ımentation, faces	heet, and i	nsurance car	rds to the Outpation	ent Infusio	n Center at 580-53	31-4779	



SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES $\underline{\mathsf{IRON}\,\mathsf{PRODUCTS}\,\mathsf{ORDER}\,\mathsf{FORM}}$

STAT	ΓRE	FER	RAL

	NT INFORMATION						_
	ame:						
HT:	in WT:kg Sex:	le Female Allerg	ies: NKDA,				
Physic	ian Name	(Contact Name _		Contac	t Phone #	
NPI #:		Tax ID#:			Fax #:		
	EMENT OF MEDICAL NECESSITY y Diagnosis: (ICD-10 Code plus Description)						
Date o	f Diagnosis:						
PERT	NENT MEDICAL HISTORY						
Does	patient have venous access?	☐ NO If yes, what	type \square ME	DIPORT	PIV PICC LINE	☐ OTHER:	
	CRIPTION ORDERS a) ALL MEDIPORTS/IV ACCESS WILL BE ACCE b) ALL PRODUCTS WILL BE PREPARED AND A c) SUPPORTING LABWORK AND DOCUMENTA d) 500 mL BAG OF 0.9% NS MAY BE HUNG AT	DMINISTERED FOLLOWII TION OF ORAL IRON TRE	NG HOSPITAL PO	DLICY		IDELINES	
SELECT	MEDICATION	DOSE	ROL		FREQ	UENCY	DURATION
	VENOFER	mg	IN	V			
	VENOFER	200 mg	I\	٧	ONCE EV	ERY WEEK	5 Doses
	INJECTAFER	750 mg	IV	V	ONCE EV	ERY WEEK	2 Weeks
	FERRLECIT	125 mg	IV.	V			
	FERRLECIT	250 mg	IV.	V			
	FERAHEME	510 mg	IV.	V	ONCE, THEN REPEA	AT 3 – 8 DAYS LATER	2 Doses
	OTHER:						
		·					
PREM	EDS MEDICATION	DOSE	ROUTE	LABS SELECT	LAB REQUESTED	WHEN	FREQUENCY
JELEGI				BELOW			
	NONE	NA	NA		NONE	NA	NA
	BENADRYL	50 mg	IV		ВМР	☐ PRIOR ☐ POST	
	ACETAMINOPHEN				СМР	☐ PRIOR ☐ POST	
	OXYGEN				BUN/CREATININE	☐ PRIOR ☐ POST	
	EPINEPHRINE	0.3mg / 0.3mL	IM		H+H:	☐ PRIOR ☐ POST	
	SOLU-MEDROL	125 mg	IV		Ferritin:	☐ PRIOR ☐ POST	
	Other:				Other:	☐ PRIOR ☐ POST	
NOTE	S:						
Physi *Signa	cian's Signature ture Must Be Clear and Legible			Tin	ne	_ Date	
Cosig *Signa	nature (If Required) ture Must Be Clear and Legible			Tin	ne	Date	
	Fax completed form, supporting do	cumentation, faces	heet, and insi	urance cards	to the Outpatient Infusio	n Center at 580-531-47	7 9.



SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES LEQEMBI ORDER FORM

STAT	FREI	FERR	AL

PATIENT INFORMATION								
Last Name:		First N	lame:				MI	_ DOB:
HT: in WT:	_kg Sex:	Female Allergies:	☐ NKDA,					
Physician Name		Contac	t Name		Conta	act Phone #		
NPI #:								
Does patient have venous access	? YES NO	If yes, what type	☐ MEDIPORT	☐ PIV	☐ PICC LINE	☐ OTHER	:	
-/	CCESSES WILL BE FLUSHED IS MAY BE HUNG AT KVO RA		INE PER HOSPITAL F	PROTOCOL PR	RN			
Perform IV si	ROM BELOW: flush every week te care per hospital protoco g IVP per hospital protocol.							
DUAL DIAGNOSIS IS REQUIRE	D – SELECT ONE OPTION	OF BOTH CONDITIO	NS THAT APPLY F	ROM BELOV	N:			
□ G30.0 Alzheimer's Disease □ G30.1 Alzheimer's Disease □ G30.8 Other Alzheimer's disease, □ G30.9 Alzheimer's disease,	Late Onset	0.X codes require ary F02.8X code →			ut behavioral distur ehavioral disturba			
□ G31.84 Mild Cognitive Impa □ Other:			(ICD 10 + Des	cription)				
			(. ,				
Prescriber must indicate	the following require	ments have beer	n met (please p	rovide do	cumentation):			
□ Beta Amyloid Pathology Co	nfirmed Via							
□ Amyloid PET Scan Date:		OR	□ CSF Analysis	Date:	Res	sult:		
□ Cognitive Assessment Used			•					
 □ ApoE ε4 Genetic Test Date 								
□ Apoli 84 Genetic Test Date	·	Nesuit.	LLI Homozygote	L Hetert	ozygote Nonc	arrier		
PRESCRIPTION ORDERS								
Leqembi	10 mg/kg	IV Over At L	east 60 Minute	S	Every 2 We (at least 14 days			12 Months
DRUG	DOSE	RO	UTE		FREQUENCY	Y		DURATION
Pre-Infusion:								
✓ Confirm MRI of Measure and ✓ Measure and ✓ Hold infusion • Headar • Dizzine • Nauser • Vision of New or Post-Infusion:	ess.	ed by prescriber preach treatment to if patient reports	ior to the 5th, 7 ² determine dose :			ening confus	ion.	
Physician's Signature				Time_		Date		
Physician's Signature *Signature Must Be Clear and Leg	gible			-				
Cosignature (If Required)				Time		Date		
*Signature Must Be Clear and Leg								

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 580-531-4779.



SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES LEQVIO ORDER FORM

STAT	REFE	RRAL

PATIE	NT INFORMATION					
Last N	lame:	First Name:	DOB:			
HT:	in WT:kg Sex: [☐ Male ☐ Female Allergie	es: 🗖 NKDA,			
Physic	cian Name	C	ontact Name		Contact Phone #	
NPI#:		Tax ID#:			_ Fax #:	
STATI	EMENT OF MEDICAL NECESSITY					
Primar	ry Diagnosis: (ICD 10 CODE + DESCRIP	TION)	Secondary D	liagnosis: (ICD 10 CODE	+ DESCRIPTION)	
PRES	patient have venous access?	S WILL BE FLUSHED WITH HE	PARIN OR SALINE F	PER HOSPITAL POLICY		
	.,		32201111011001111			
ECT	MEDICATION LEQVIO (LOADING DOSES	DOSE 284 mg	ROUTE		FREQUENCY d 3, then every 6 months	DURATION
			,		•	
	LEQVIO (MAINTENANCE DOS	SES) 284 mg	SQ	E ¹	very 6 months	
LABS		FREQUENCY				
LECT	LAB REQUESTED	FREQUENCY				
:	2) HETEROZYGOUS FAMILIAL HYPERO 3) PLEASE MARK ANY OF THE FOLLOV PRESENCE OF TENI FAMILY HISTORY OF	NCLUDE ANY PAST TRIED AND/O CHOLESTEROLEMIA (HEFH) - DOI WING CRITERIA THE HEFH PATIE DON XANTHOMA(S) IN THE PATIE F MI AT <60 YEARS OLD IN 1ST D F TOTAL CHOLESTEROL > THAN	ES THE PATIENT HAVI ENT MEETS: ENT OR 1ST/2ND DEGI DEGREE RELATIVE OR	E A UNTREATED LDL ≥ 190 REE RELATIVE <50 YEARS OLD IN 2 ND DE	TS, OR CONTRAINDICATIONS TO CONVE DMG/DL (≥ 155MG/DL IF <16 YEARS OF AG GREE RELATIVE	
	4) ASCVD - DOES THE PATIENT'S LDL	REMAIN ≥ 100MG/DL DESPITE TF	REATMENT WITH A HIG	GH-INTENSITY STATIN?	YES □ NO	
	5) HAS THE PATIENT TRIED AND FAILE	ED PCSK9 INHIBITOR AFTER 12 V	VEEKS OF USE? T	ES 🗆 NO		
(6) HAS THE PATIENT TRIED AND FAILE	ED A HIGH INTENSITY STATIN FO	R≥8 CONTINUOUS W	EEKS? 🗆 YES 🗆 NO		
•				☐ TRANSIEN	OF MYOCARDIAL INFARCTION NT ISCHEMIC ATTACK	
;	8) INCLUDE LABS AND/OR TEST RESU LDL-C (Required) MUTATION IN LDL, A	LTS TO SUPPORT DIAGNOSIS APOB, OR PCSK9 GENE (If Applic	cable)			
!	9) OTHER MEDICAL NECESSITY:					-
	cian's Signature ture Must Be Clear and Legible			Time	Date	-
Cosig	nature (If Required)			Time	Date	_
*Signa	ture Must Be Clear and Legible					



SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES NEUROLOGY ORDER FORM

	IENT INFORMATION Name:		First Na	me:		MI DOB:	
	in WT:kg Sex: □						
Phvs	sician Name		Contact I	Name	Con	tact Phone #	
	#:						
STA	TEMENT OF MEDICAL NECESSITY						
Prima	ary Diagnosis: ICD 10 + Description:				Date of D	Diagnosis:	
PER.	TINENT MEDICAL HISTORY						
Does	s patient have venous access?	NO If yes, who	at type	☐ MEDIPORT	☐ PIV ☐ PICC LINE	OTHER:	
PRE	SCRIPTION ORDERS:						
	a) ALL MEDIPORTS / IV ACCESSES WILL				POLICY		
	b) ALL PRODUCTS WILL BE PREPARED Ac) 500 mL BAG OF 0.9% NS MAY BE HUNG		VING HOSF	PITAL POLICY			
LECT	MEDICATION /			ROUTE	FREQUE	-NCY	DURATION
_	TYSABRI 300 mg			IV	1112401		12 MONTH
Ш	*PATIENT WILL BE OBSERVED FOR 1	HOUR POST INFUSION					
	OCREVUS LOADING DOSES			IV	300 mg at 0, 2 weeks, then 60	Omg once every 6 months	
	OCREVUS 600 mg MAINTENANCE DO	SES		IV	Once every	6 months	
<u> </u>				IV			
	SOLU-MEDROLmg						
PRE	MEDS			LABS	·		
LECT	MEDICATION BENADRYL	DOSE	ROUTE			WHEN	FREQUEN
						☐ PRIOR ☐ POST	
	ACETAMINOPHEN				CMP	☐ PRIOR ☐ POST	
_	SOLUMEDROL				BUN/CREATININE	□ PRIOR □ POST	
	OXYGEN			┤├╬	JCV ANTIBODY		EVERY 6
	FAMOTIDINE				(Patients taking Tysabri)	PRIOR POST	MONTHS
	FAMOTIDINE				CRP	☐ PRIOR ☐ POST	
	Other:				ESR	☐ PRIOR ☐ POST	
 ¬	Other:			│	Other:		
NOT	ES/INSTRUCTIONS/COMMENTS:						
					_		
	sician's Signature nature Must Be Clear and Legible				Time	Date	
	ignature (If Required)				Time	Date	
	nature Must Be Clear and Legible						



SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES OSTEOPOROSIS ORDER FORM

1	
STAT	REFERRAL

	INFORMATION e: First Name:			MI DOB:	
	in WT: kg Sex:				
	Name Contact Name Tax ID#:				
	ENT OF MEDICAL NECESSITY iagnosis: (ICD-10 CODE + DESCRIPTION)		Date o	f Diagnosis:	
	NT MEDICAL HISTORY ent have venous access? YES NO If yes, what type MEDIPORT] PIV 🗀	PICC LINE	OTHER:	
a) b) PRESCRI	ALL MEDIPORTS/IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE OR HEPARIN PER HOS 500 mL BAG OF 0.9% NS MAY BE HUNG AT KVO RATE PRION ORDERS	PITAL POLICY	,		
SELECT	MEDICATION	DOSE	ROUTE	FREQUENCY	DURATION
	RECLAST (ZOLEDRONIC ACID) ADMINISTER OVER NO LESS THAN 15 MINUTES BUN, CREAT, AND CALCIUM LEVEL WITHIN 90 DAYS OF APPOINTMENT HOLD IF CALCIUM LEVELS < 8.5mg/dL or IONIZED CALCIUM LEVEL < 4.5mg/dL or IF CRCL < 35 ML/MIN	5 mg	IV	ONCE EVERY 12 MONTHS	1 Year
	PROLIA (DENOSUMAB) BUN, CREAT, CALCIUM LEVEL WITIN 90 DAYS OF THE APPOINTMENT HOLD IF CALCIUM LEVELS < 8.5mg/dL or IONIZED CALCIUM LEVEL < 4.5mg/dL or IF CRCL < 30 ML/MIN	60 mg	SC	ONCE EVERY 6 MONTHS	1 Year
	EVENITY BUN, CREAT, CALCIUM LEVEL WITIN 90 DAYS OF THE APPOINTMENT HOLD IF CALCIUM LEVELS < 8.5 mg/dL or IONIZED CALCIUM LEVEL < 4.5 mg/dL or IF CRCL < 30 ML/MIN	210 mg	SC	ONCE EVERY MONTH x 12	1 Year
1) • • • 2) 3) *OSTEOP DENISTY *PLEASE	TING DOCUMENTATION FOR PATIENTS RECEIVING RECLAST, PROLIA, OR EVINITY: OSTEOPOROSIS: CALCIUM, BUN, AND SERUM CREATININE MUST BE CHECKED WITHIN THE LAST 90 DA' ORIGINAL BONE DENSITY/DEXA SCAN SUPPORTING THE DIAGNOSIS OF OSTEOPOROSIS IN THE PATIENT F PRIOR/CURRENT MEDICATIONS USED TO TREAT THE DIAGNOSIS OF OSTEOPOROSIS IN (Examples: Oral calcium, Vitamin D, Bisphosphonates) MEN AT HIGH RISK OF FRACTURE RECEIVING ANDROGEN DEPRIVATION THERAPY FOR TREATMENT TO INCREASE BONE MADD IN WOMEN AT HIGH RISK FOR FRACTURE RECEIVING ANDROGEN DEPRIVATION THERAPY FOR THE ATMENT TO INCREASE BONE MADD TO THE DIAGNOSIS OF OSTEOPOROSIS OR DOCUME PENIA IS NOT AN APPROVED DIAGNOSIS FOR PROLIA (DENOSUMAB). PATIENTS WITH IMPRESULT OR DEXA SCAN SUPPORTING THE DIAGNOSIS OF OSTEOPOROSIS OR DOCUME SUBMIT DOCUMENTATION OF ANY TRIED AND FAILED ORAL / INJECTIBLE MEDICATIONS SE / FAILURE TO TREATMENT.	RECORD DA' MUST BE DO R NONMETA EIVING ARC PRESSIONS OF	FED WITHIN 1 CUMENTED I STATIC PROS MATASE INH OF OSTEOPE A PREVIOUS	YEAR PRIOR TO APPOINTMEN N PATIENT'S MEDICAL RECOR STATE CANCER IBITOR THERAPY FOR BREAST NIA MUST HAVE AN ORIGINAL S FRAGILITY FRACTURE.	D CANCER
*PROLIA	IS CONTRAINDICATED IN PATIENTS WITH HYPOCALCEMIA.				
	n's SignatureTin e Must Be Clear and Legible	ne		Date	
	ure (If Required)Tin	ne		Date	

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 580-531-4779.



SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES $\frac{\text{RHEUMATOLOGY ORDER FORM}}{\text{Constitution}}$

STA	١T	RE	EFE	RR	AL

	T INFORMATION ame:		Firet Nar	ma.			MI	DOR:
HT:	in WT:kg Sex:	Female Alle	ergies: L Ni	KDA,				
Physicia	n Name	C	Contact Name			Contact Pho	one #	
NPI #:						Fax #:		
	MENT OF MEDICAL NECESSITY Diagnosis: (ICD-10 Code plus Description)							
PERTIN	ENT MEDICAL HISTORY							
Does pa	atient have venous access? YES NO	If yes, wh	nat type] МЕ	DIPORT	☐ PIV ☐ PICC LINE	OTHER:	
1) TB tes	st performed? O Yes O No Date:	Results,						
	B antigen surface antibody test? O Yes O No Date:							
PRESCR	nt previously treated with any of the following: (please select RIPTION ORDERS: MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH SA					nlysta O Rituxan O Orencia O Ad	ctemra O Stelara, Date:	
b) ALL P	PRODUCTS WILL BE PREPARED AND ADMINISTERED F	OLLOWING HO	SPITAL POLIC	CY				
,	IL BAG OF 0.9% NS MAY BE HUNG AT KVO RATE							
	DAING DOSES HAVE BEEN INITIATED, LIST DOSE IN CY	CLE TO BE GIV						
LECT	MEDICATION		DOSE		ROUTE		QUENCY	DURATION
	Actemra	10 /	_mg/kg					
	Benlysta Loading Dose(s)	10 mg /			IV	0, 2, 4 Weeks, Then Onc	e Every 4 Weeks	
	Benlysta Maintenance Dose	10 mg /	kg		IV	Once Every 4 Weeks		
	Krystexxa	8 mg			IV	Once Every 4 Weeks		
	Orencia Loading Dose(s)	-	mg		IV	0, 2, 4 Weeks, Then Onc		
	Orencia Maintenance Dose(s)	500 mg	500 mg		IV	Once Every 4 Weeks		
	Orencia Maintenance Dose(s)	750 mg			IV	Once Every 4 Weeks		
	Orencia Maintenance Dose(s)	1000 mg	I		IV	Once Every 4 Weeks		
	Remicade Loading Dose(s)		mg	/ kg	IV	0, 2, 6 Weeks, Then Once EveryWeeks		
	Remicade Maintenance Dose(s)		mg	/ kg	IV	Once EveryWeeks		
	Rituxan	—	mg	/ kg	IV	Once EveryWee	eks	
	Simponi Aria		mg	/ kg	IV	Once EveryWee	eks	
	Stelara Loading Dose(s)		mg		IV	Once		1
PREMEI	*SC administration is NOT covered Outpatient				LABS			
LECT	MEDICATION	DOSE	ROUTE	1	SELECT	LAB REQUESTED	WHEN	FREQUENCY
	NONE	NA	NA			NONE	NA	NA
	BENADRYL					ВМР		
	ACETAMINOPHEN					CMP		
	OXYGEN					BUN/CREATININE		
	SOLU-MEDROL					CRP		
	ONDANSETRON			4		ESR		
	FAMOTIDINE					ALT		
	Other:			4		AST		
<u> </u>	Other:			4		LIVER PANEL OTHER:		
	Other:			ال		UINEK:		
	ian's Signature re Must Be Legible					_Time	Date	_
Cosign	nature (If Required) ire Must Be Legible					Time	Date	_
<u> </u>	Fax completed form, supporting docum	entation, fac	esheet, an	nd ins	surance cai	rds to the Outpatient Infus	ion Center at 580-531	-4779 .



SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES THERAPEUTIC PHLEBOTOMY ORDER FORM

STAT	REFERRAL

ast N	ame:			First Name:			MI	_ DOB:
HT:		in WT:kg Sex	: Male Female	e Allergies: NKDA	Λ,			
						Contact Pho		
		OF MEDICAL NECESSITY						
Primar	y Diagno	osis: (ICD 10 CODE + DESCR	RIPTION)	Seco	ndary Diagnosis: (ICD 10 CODE + DESCRIPTION)		
PRESC	CRIPTIC	N ORDERS						
a) b)		L MEDIPORTS / IV ACCESSES \ mL NS Flush Syringe PRN	WILL BE FLUSHED WITH	HEPARIN OR SALINE PER	HOSPITAL POLICY	PRN		
c)		RDERS WITH INCOMPLETE PAR	RAMETERS WILL NOT BE	SERVICED				
REATM	ENT	mL TO REMOVE	(+/- 50 mL)	PARAMATE	RS	FREQUENCY		DURATION
						1 x only		
Therape				HOLD if ≤		Weekly		
Phleboto	omy					└── Monthly		
						Other:		
LABS		LAR REQUESTER	I FDEO	HENCY	NOTES/INS	TRUCTIONS/OTHER	I	
	NONE	LAB REQUESTED	NA FREQ	UENCY	-			
	CBC	v/ Diff	PRIOR TO EACH PH	ILEBOTOMY	-			
	Hgb		PRIOR TO EACH PH	ILEBOTOMY	-			
	Hct		PRIOR TO EACH PH	ILEBOTOMY	_			
	ВМР				-			
	СМР				-			
<u> </u>	BUN/0	CREATININE			-			
	ESR				1			
	CRP				-			
<u>-</u>	СРК				1			
	Ferriti	n			-			
	Other	:			1			
	Other	:						
	<u> </u>		1		1			
Physic	ian'e Si	ignature			Tim	p Do	te	
*Signa	ture Mus	st Be Clear and Legible			11111	Da		
Cosigi	nature (If Required) st Be Clear and Legible			Time	e Da	te	
Sigria		-				o the Outpatient Infusion Ce		



Phone: 580-531-4892 Fax: 580-531-4779

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES VENOFER (IRON SUCROSE) ORDER FORM

STAT	REFE	RRAL

an Name_	in WT:kg Sex:□	Male Fem	nale Allergies						
MENT OF									
MENT OF			Cor	ntact Name	e		Contac	ct Phone #	
	F MEDICAL NECESSITY is: (ICD-10 Code plus Descriptio	n)							
Diagnosis	s:								
		Пио	lf	🗖	MEDIDODE [7 mv	D DIGGLINE	□ otuen.	
		□ NO	ir yes, what ty	ре ப	WEDIPORT L	→ PIV	☐ PICC LINE	U OTHER:	
		BE ACCESSED	O AND FLUSHE	D WITH S	SALINE OR HEPA	ARIN PEF	R HOSPITAL PROTO	COL	
) ALL	PRODUCTS WILL BE PREPAR	ED AND ADMIN	NISTERED PER	STANDA	RD PHARMACY	CONCE	NTRATIONS AND HO	OSPITAL POLICY	
TION	DOSE		ROUTE			F	REQUENCY	DU	JRATION
R			IV			Every_	days		
:ne					LARS				
	MEDICATION		DOSE	ROUTE			AB REQUESTED	WHEN	FREQUENC
NONE		NA		NA		NONE	<u> </u>	NA NA	NA
BENAD	RYL	50 mg		IV		ВМР		☐ PRIOR ☐ POST	
ACETAI	MINOPHEN					CMP		☐ PRIOR ☐ POST	
OXYGE	N					BUN/0	CREATININE	☐ PRIOR ☐ POST	
EPINEP	HRINE	0.3mg	/ 0.3ml	IM		H+H:		☐ PRIOR ☐ POST	
SOLU-N	MEDROL	125 mg	g	IV		Ferriti	n:	☐ PRIOR ☐ POST	
Other:						Other	:	☐ PRIOR ☐ POST	
) :									
ian's Sigı	nature				т	ime		Date	
	-								
				-	Т	ime		Date	
(a) (b) (b) (c) (c) (d) (d) (d) (d) (d) (d) (d) (d) (d) (d	RIPTION ALL ALL SUP TION R BENAD ACETAI OXYGE EPINEP SOLU-M Other: ::	RIPTION ORDERS ALL MEDIPORTS/IV ACCESS WILL ALL PRODUCTS WILL BE PREPAR SUPPORTING LABWORK AND DOC TION DOSE MEDICATION NONE BENADRYL ACETAMINOPHEN OXYGEN EPINEPHRINE SOLU-MEDROL Other: :: ::	ALL MEDIPORTS/IV ACCESS WILL BE ACCESSED ALL PRODUCTS WILL BE PREPARED AND ADMIN SUPPORTING LABWORK AND DOCUMENTATION FION DOSE R MEDICATION NONE NA BENADRYL ACETAMINOPHEN OXYGEN EPINEPHRINE SOLU-MEDROL Other: :: ian's Signature ure Must Be Clear and Legible ature (If Required) ure Must Be Clear and Legible	RIPTION ORDERS ALL MEDIPORTS/IV ACCESS WILL BE ACCESSED AND FLUSHE ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED PEF SUPPORTING LABWORK AND DOCUMENTATION OF ORAL IRC FION DOSE ROUTE R IV BENADRYL 50 mg ACETAMINOPHEN OXYGEN EPINEPHRINE 0.3mg / 0.3ml SOLU-MEDROL 125 mg Other: Carrier Signature Lure Must Be Clear and Legible ature (If Required) Lure Must Be Clear and Legible ature (If Required) Lure Must Be Clear and Legible	Accessed and Flushed With Support Supp	Acetaminophen Oxygen Epinephrine Oxygen Epinephrine Oxygen Epinephrine Oxther: Idian's Signature Internation or All Mediplor of Signature Internation of Signature	atient have venous access?	atient have venous access?	RIPTION ORDERS ALL MEDIPORTS/IV ACCESS WILL BE ACCESSED AND FLUSHED WITH SALINE OR HEPARIN PER HOSPITAL PROTOCOL ALL PRODUCTS WILL BE PREPARED AND ADMINISTERED PER STANDARD PHARMACY CONCENTRATIONS AND HOSPITAL POLICY SUPPORTING LABWORK AND DOCUMENTATION OF ORAL IRON TREATMENT MAY BE REQUIRED BASED ON INDIVIDUAL PAYOR GUIDELINES TION DOSE ROUTE FREQUENCY DU R IV EVery days EDS LABS BENADRYL 50 mg IV BINDROPHEN OXYGEN 0.3mg / 0.3ml IM SOLU-MEDROL 125 mg IV BINDROPHEN DOST CHINEPHRINE 0.3mg / 0.3ml IM BINDROPHEN DOST SOLU-MEDROL 125 mg IV DICHER: Time Date attree the protocol bate and repairs and repai