Follow Up discharge orders (Plan of Care): \_\_\_\_\_\_ Call Provider with update \_\_\_\_\_\_\_ Discharge Home

Referring Provider Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Fax Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Thank you for choosing Infusion Services at CMC, located at Dartmouth-Hitchcock’s Norris Cotton Cancer Center***

Created/Revised Date: 6-2008, 2-2015

Approved by P&T/MEC: 6-2008, 2-2015

Responsible Department:  Infusion Center

**In order to complete our medical records, please verify your patient’s status in regards to the following**:

Special equipment needed during appointment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardiac/Pulmonary status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ O2 dependent: Yes or No , \_\_\_\_\_\_\_Liters/min

Interpreter Needed: Yes or No Language:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication Orders**

□ Zoledronic Acid (Reclast™) 5mg IV over 30 minutes\*\*\*

□ Ibandronate (Boniva™) 3mg IV Push over 30 seconds every 3 months x\_\_\_\_\_doses\*\*\*

□ Denosumab (Prolia™) 60mg subcutaneously every 6 months x\_\_\_\_\_doses.

□ Belimumab (Benlysta™) \_\_\_\_\_\_\_\_mg IV over 1 hour every 4 weeks x\_\_\_\_\_doses.

□ Abatacept (Orencia™) \_\_\_\_\_\_\_\_\_mg IV in 100ml NS over 30 minutes every \_\_\_\_ weeks x \_\_\_\_\_\_\_\_\_doses

□ Natalizumab (Tysabri™) 300mg IV every 4 weeks x \_\_\_\_\_\_\_doses

□ Valproic Acid (Depacon™) \_\_\_\_\_\_\_\_\_\_\_\_mg **or** \_\_\_\_\_\_\_\_\_\_mg/kg IV over 60 minutes x\_\_\_\_\_doses

□ Immune Globulin (IVIG) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_grams IV every\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ x \_\_\_\_\_\_ doses. (will be rounded appropriately for package size)

□ Methylprednisolone IV (Solu-Medrol™) 1 gram in 250ml D5W. Infuse per Infusion Policy x\_\_\_\_\_\_\_doses

□ Omalizumab (Xolair™) \_\_\_\_\_\_\_\_mg subcutaneously every \_\_\_\_\_\_\_\_\_ weeks x\_\_\_\_\_doses

\*\*\*Serum Creatinine, Serum Calcium & Serum Albumin required pre-treatment within 4-6 weeks of treatment. Fax results or Lab order. **All orders expire after 1 year from date written.**

**Other Medication orders or Hydration Order**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Premedications: x1 dose**

□Acetaminophen \_\_\_\_\_\_\_mg PO

 □Diphenhydramine \_\_\_\_\_mg PO

□Diphenhydramine \_\_\_\_\_\_mg IV

 □Loratidine 10mg oral

□Hydrocortisone \_\_\_\_\_\_\_mg IV

□Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□May repeat above ordered pre-medications for Infusion Reaction

**Rituxan™ (Rituximab)**

1000mg IV on Days 1 & 15

Infuse per Protocol

Premedication: Days 1 & 15

□Diphenhydramine 25mg IV

□Diphenhydramine 50mg IV

□Methylprednisolone 100mg IV

□Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies/Intolerances:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height:\_\_\_\_\_□Cm □ Inches, Weight:\_\_\_\_\_\_\_□Kg □Lbs

Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Prior Auth: Y/N\_\_\_\_\_\_# if known