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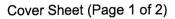
## **CONFIDENTIAL**

DATE:					
PLEASE DELIVER TO:	<u>Lewis County Health System – ASU Department</u>				
FAX #:	315-376-0130				
COMPANY:					
FROM:					
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NOTES:					

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## **OUTPATIENT SERVICES REQUEST CHECKLIST**

What is needed to schedule your patient for treatment at Lewis County General Hospital

Patient Name		DOB		Patient Phone #				
Height Weight	 Gender	Allergies	-					
Please attach separate order form for Infusion or procedure (i.e., wound care)								
Diagnosis/Indicati	ions for treatm	ent:						
Please ensure the								
Authorization	on / Insurance a	approval completed						
Refere	ence #		Date					
Autho	rization #		Date					
Patient Dem	ographic Cove	er Sheet						
LCGH speci	fic Order Shee	t completed in full?						
	Patient's name	)		Patient's DOB				
	Diagnosis			Patient's current height and weight				
	Allergies			Signed, dated, and timed by ordering physician				
Consent co	mpleted (for blo	ood products including IV	(IG)					
H&P writter	n within 30 day	rs (which includes purpo	se for d	rug)				
Print and fa	nx to LCGH Am	bulatory Outpatient	Depart	ment				
**		ure ALL boxes are che completion, schedulin		orior to faxing to LCGH ASU e done by LCGH				
Provider (or designee	e) Print Name		Phone	e # Fax #				
Provider (or designe	e's) Signature		Date					



Place patient identification sticker a	nd/or <b>two</b>
patient identifiers.	

MEDICATION	:	Ht	_ Wt	kg				
**UNAPPROVED A	BBREVIATIONS** QD, QOD, MgSO4, N	ASO4, MS, IU, U o	r -u, ug, U	se of a trailing zero (X.0mg), Lack of a				
leading zero (Xmg)								
	ORDERS GOOD F	OR THE YEAR OF	20	_				
	IT TO ASU OUTPATIENT							
Diagnosis:								
Allergies:								
Vital Signs:								
IV: 0.9% Normal Sa	line @ 30ml/hr							
Regular Diet		IC. CELECT ALL TI	JAT ADDI	V				
PRE-MEDICATIONS: SELECT ALL THAT APPLY  Methylprednisolone 40mg IV x 1 - 30 minutes prior to infusion								
	Diphenhydraminemg PO x 1 - 30	0 minutes prior to	infusion					
	Diphenhydraminemg IV x 1 - 30	minutes prior to i	nfusion					
	Acetaminophen 650mg PO x 1 - 30 min	nutes prior to infu	sion					
	Other:							
M	edication (If ordering an antibiotic	or anticoagulant	. clinical	indication is required)				
111	calcation (if ordering an analysis	or unitrodugation is	,	·				
IF INFUSION-RELA	ATED REACTION OCCURS (FOR ALL C							
			RN medica	ations per infusion reaction medications				
1. STOP infusion		listed below						
	onse team (if clinically indicated)	5. Notify Physici						
3. Increase 0.9% N	ormal Saline to 999 ml/hr	6. Vital signs ever ACTION MEDICA		lutes				
Fallow reaction inf	usion protocol unless otherwise indica							
				eezing				
Albuterol 2.5mg via nebulizer x1 as needed for shortness of breath/wheezing  Diphenhydramine 25mg IV every 15 mnutes x2 as needed for urticaria, pruritis, shortness of breath								
<ul><li>Epinephrine 0.3mg IM x 1 as needed for anaphylaxis</li><li>Methylprednisolone Succinate 125mg IV x 1 as needed for anaphylaxis</li></ul>								
NURSING ORDERS								
• Monitor	patient for 30 minutes after infusion is	complete.						
			ed by Her	parin 500 units (if applicable)				
• Access port-a-cath, flush with 0.9% NS 10mL post infusion, followed by Heparin 500 units (if applicable)								
Use PICC line, flush with NS 10mL post infusion with 0.9% NS (if applicable)								
Discharg	ge when criteria met.							
<ul><li>Other:</li></ul>				1				
Nurs	se Signature:	Date:	_ Time:					
Qualified Medical Provider Name (Print) :								
	,	NPI#:						
	Date:	Time:	12	LCGH.0005				