Lewis County Health System

7785 North State Street
Lowville, New York 13367
Phone 315-376-5200
Fax 315-376-0130
www.lcgh.net

CONFIDENTIAL

DATE: ______________________

PLEASE DELIVER TO: Lewis County Health System – ASU Department

FAX #: 315-376-0130

COMPANY: ______________________

FROM: ______________________

NUMBER OF PAGES (INCLUDING COVER SHEET): 3

SUBJECT: **INFUSION REQUEST**

NOTES: ______________________

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Lewis County Health System
Your Health Partner

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/Indications for treatment:

____

Please ensure the following are attached:

☐ **Authorization / Insurance approval completed**

Reference # ____________ Date ____________

Authorization # ____________ Date ____________

☐ **Patient Demographic Cover Sheet**

☐ **LCGH specific Order Sheet 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 completed** (for blood products including IVIG)

☐ **H&P written within 30 days** (which includes purpose for drug)

☐ **Print and fax to LCGH Ambulatory Outpatient Department**

> **Please make sure **ALL** boxes are checked prior to faxing to LCGH ASU
> Upon completion, scheduling will be done by LCGH

Provider (or designee) Print Name ____________ **Phone #** ____________ **Fax #** ____________

Provider (or designee's) Signature ____________ **Date** ____________

Fax completed form to: 315-376-0130 / Contact us directly at: 315-376-5233 / Visit us online at: lcgh.net

Lewis County Health System

DOCTOR'S ORDER SHEET - PHARMACY

Place **patient identification sticker** and/or **two patient identifiers.**

Entyvio (vedolizumab) Infusion

Ht _____ Wt _____kg

ORDERS GOOD FOR THE YEAR OF 20_____

☐ **ADMIT TO ASU OUTPATIENT**

Diagnosis:

Allergies:

Vital Signs: Every 15 minutes

IV: 0.9% Normal Saline @ 30ml/hr

Regular Diet

Date of last negative TB ______________________________

PRE-MEDICATIONS: SELECT ALL THAT APPLY

☐ Methylprednisolone 40mg IV x 1 - 30 minutes prior to infusion

☐ Diphenhydramine _____mg PO x 1 - 30 minutes prior to infusion

☐ Diphenhydramine _____mg IV x 1 - 30 minutes prior to infusion

☐ Acetaminophen 650mg PO x 1 - 30 minutes prior to infusion

☐ Other:

Medication: Below products are specific to insurance approval

☐ Entyvio (vedolizumab)

ADMINISTER INFUSION AS FOLLOWS:

Dose 300mg IV in 0.9% Sodium Chloride over 30 minutes.

FREQUENCY: (Choose one)

☐ **- on weeks 0, 2, 6 and then every 8 weeks thereafter**

☐ **- every 8 weeks**

IF INFUSION-RELATED REACTION OCCURS (FOR ALL ORDERS):

1. **STOP infusion**
2. **Alert rapid response team (if clinically indicated)**
3. **Increase 0.9% Normal Saline to 999 ml/hr**
4. **Administer PRN per infusion reaction medications listed below**
5. **Notify Physician**
6. **Vital signs every 10 minutes**

INFUSION REACTION MEDICATIONS

Follow reaction infusion protocol unless otherwise indicated (FOR ALL ORDERS):

☐ 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

☐ Other:

NURSING ORDERS

- Recommended for providers to routinely monitor CBC, LFTs every 8 weeks.
- Flush infusion line with 30mL of 0.9% Sodium Chloride after infusion complete
- Do not infuse with any other agents in this line
- Do not administer infusion if patient has signs/symptoms of a current infection - and notify the provider
- Monitor patient for signs/symptoms of hypersensitivity/infusion reaction during and for 30 minutes after infusion is complete.
- Access port-a-cath, flush with 0.9% NS 100mL post infusion, followed by Heparin 500 units (if applicable)
- Use PICC line, flush with NS 10mL post infusion with 0.9% NS (if applicable)
- Discharge when critera met

Nurse Signature: ______________________________ Date: __________ Time: ________

Qualified Medical Provider Name (Print) : ______________________________

Signature: ______________________________ **Date:** ___________

Phone Number: ____________________ **Time:** ___________

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