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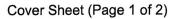
CONFIDENTIAL

DATE:	
PLEASE DELIVER TO:	Lewis County Health System – ASU Department
FAX #:	315-376-0130
COMPANY:	
FROM:	
NUMBER OF PAGES (INCLUDI	NG COVER SHEET):
SUBJECT: INFUSION REQU	EST
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 #			
			_	r dient i none #			
Height Weig	ht Gender	Allergies					
Please attach separate order form for Infusion or procedure (i.e., wound care)							
Diagnosis/Indic	ations for treatm	ent:					
Please ensure th	ne following are a	nttached:					
- Authoriza	tion / Incurance	approval completed					
Authoriza	ition / insurance	approvai completed					
Re	ference #		Date				
Au	thorization #	-	Date				
Patient De	emographic Cove	er Sheet					
LCGH spe	ecific Order Shee	t completed in full?					
	Patient's name	9		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 desig	nee) Print Name		Phone				
i iovidei (oi desig		<u></u>					
Provider (or desig	nee's) Signature		Date				



NPI#: _____

DOCTOR'S ORDER SHEET

Place patient identification sticker and/or two patient identifiers.

LCGH.0005

IRON SUCROSE INFUS	SION Ht Wt (kg)						
ORDI	ERS 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							
PRE-N	MEDICATIONS: SELECT ALL THAT	APPLY					
Methylprednisolone 40mg IV x	1 - 30 minutes prior to						
Diphenhydraminemg PO	Diphenhydraminemg PO x 1 - 30 minutes prior to infusion						
Diphenhydraminemg IV x 1 - 30 minutes prior to infusion							
Acetaminophen 650mg PO x 1 -	30 minutes prior to infusion						
Other:							
Walls in	MEDICATION						
Iron Sucrose 500mg IV on day 1	and then again on day 14.						
Iron Sucrose 200mg IV - 5 doses	Iron Sucrose 200mg IV - 5 doses spread out over a 14-day period.						
Iron Sucrosemg IV (max dos	e in one visit 500mg- Total cumulativ	e dose 1000mg in a 14-day period.					
FREQUENCY:							
Administer IV Infusion as follows:	500mg dose @72mLs/hr	300mg dose @ 167mLs/hr					
	400mg dose @ 100mLs/hr	200mg dose @ 200mLs/hr					
IF INFUSION-RELATED REACTION OCCU							
1. STOP infusion	5. Notify Physic						
2. Alert rapid response team (if clinically i		very 10 minutes					
3. Increase 0.9% Normal Saline to 999 ml/							
4. Administer PRN medications per infusion	USION REACTION MEDICAT	IONS					
		IONS					
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						
possessing and the second seco	, 13 muces X2 as needed for diction	a, prantis, shorthess or breath					
Other: NURSING ORDERS							
Monitor patient's vital signs duri		nlete					
	Monitor patient's vital signs during and 30 minutes after infusion complete Monitor patient for hypersensitivity reactions						
	Monitor patient's IV site for extravasation and phlebitis						
	• 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) 							
 Discharge when criteria met 							
Nurse Signature:	Date: Time:						
Qualified Medical Provider Name (Print):							
Signature:	Date:						