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: _____

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.**

Simponi Aria (golimumab) Infusion

Ht _____ Wt _____kg

ORDERS GOOD FOR THE YEAR OF 20_____

☐ **ADMIT TO ASU OUTPATIENT**

Diagnosis:

Allergies:

Vital Signs: Every 15 minutes during first hour, then every 30 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

- ☐ Simponi Aria (golimumab)

ADMINISTER INFUSION AS FOLLOWS:

Doses 2mg/kg (IV in 0.9% NS to total volume of 100mLs and infuse 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 medications 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

- Weight should be recorded at every visit. Notify Pharmacy with patients current weight.
- Recommended to routinely monitor for TB, signs/symptoms of demyelinating disease, heart failure and infection, and repeat labs every 8 weeks.
- Hold infusion and notify MD if patient has signs / symptoms of infection or significant change in clinical status
- Monitor patient for 30 minutes after infusion complete
- 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: _____ **NPI#:** _____

Phone Number: _____ **Date:** _____ **Time:** _____

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