

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

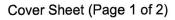
CONFIDENTIAL

DATE:			
PLEASE DELIVER TO:	<u>Lewis County Health System – ASU Department</u>		
FAX #:	315-376-0130		
COMPANY:			
FROM:			
NUMBER OF PAGES (INCLUDI	NG COVER SHEET): 3		
SUBJECT: INFUSION REQU	UEST		
NOTES:			

THIS INFORMATION IS INTENDED FOR THE USE OF THE INDIVIDUAL TO WHOM OR ENTITY TO WHICH IT IS ADDRESSED AND MAY CONTAIN INFORMATION THAT IS PRIVILEGED, CONFIDENTIAL AND EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAW.

IF THE READER OF THIS INFORMATION IS NOT THE INTENDED RECIPIENT OR THE EMPLOYEE OR AGENT RESPONSIBLE FOR DELIVERING THE MESSAGE TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION, OR COPYING OF THIS COMMUNICATION IS PROHIBITED. IF YOU HAVE RECEIVED THIS INFORMATION IN ERROR, PLEASE NOTIFY US IMMEDIATELY BY TELEPHONE. THANK YOU.

IF YOU DO NOT RECEIVE ALL THE PAGES OR IF THE QUALITY IS NOT SUITABLE, PLEASE CALL 315-376-5200 AS SOON AS POSSIBLE. THANK YOU.





OUTPATIENT SERVICES REQUEST CHECKLIST

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

Patient Name	DOB	Patient Phone #	
	Allergies		
Height Weight Gender	Allergies		
Please attach separate order fo	orm for Infusion or proced	dure (i.e., wound care)	
Diagnosis/Indications for treat	ment:		
Please ensure the following are	attached:		
Please ensure the following are	attacheu.		
Authorization / Insurance	approval completed		
Reference #		ate	
Authorization #		ate	
Patient Demographic Co	er Sheet		
LCGH specific Order She	et completed in full?		
Patient's nan	ne	Patient's DOB	
Diagnosis		Patient's current height and we	eight
Allergies		Signed, dated, and timed by or	rdering physician
Consent completed (for I	plood products including IVIG)		
H&P written within 30 da	ays (which includes purpose for	for drug)	
Print and fax to LCGH A	mbulatory Outpatient Dep	partment	
	All I	and purious to foreign to 1 CCL1 ACL1	
	sure ALL boxes are cnecken n completion, scheduling wi	ed prior to faxing to LCGH ASU ill be done by LCGH	
		-	
Provider (or designee) Print Name	Pr	hone# F	ax #
Provider (or designee's) Signature		ate	



Place patient identification	sticker and/or two patient
identifiers.	

Simponi Aria (golimumab) Infusion Ht Wtkg	
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):	
4. Administer PRN medications per infusion reaction medications	
1. STOP infusion listed below	
2. Alert rapid response team (if clinically indicated) 5. Notify Physician 6. Witel sizes a company 10 principles	
3. Increase 0.9% Normal Saline to 999 ml/hr 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	ıt
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 	
With the first the second to t	
 Access port-a-cath, flush with 0.9% NS 10mL post infusion, followed by Heparin 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) Discharge when criteria met 	

Qualified Medical Provider Name (Print): _______ NPI#: _____ Phone Number: _____ Date: _____ Time: ______ I