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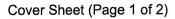
CONFIDENTIAL

DATE:			
PLEASE DELIVER TO:	Lewis County Health System – ASU Department		
FAX #:	315-376-0130		
COMPANY:			
FROM:			
NUMBER OF PAGES (INCLUDI	NG COVER SHEET): 3		
SUBJECT: INFUSION REQU	TEST		
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/Indication	ns for treatme	ent:					
Please ensure the fol	llowing are at	tached:					
Authorization	/ Insurance a	pproval completed					
Reference	ce #		Date				
Authoriz	ation #	-	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				



Zoledronic Acid	Ht Wtkg					
ORDERS GOOD FOR TH	IE YEAR OF 20					
ADMIT TO ASU OUTPATIENT						
Diagnosis:						
Allergies:						
Vital Signs: Every 30 minutes.						
IV: 0.9% Normal Saline @ 30ml/hr						
Regular Diet PRE-MEDICATIONS: SEL	ECT ALL THAT APPLY					
Methylprednisolone 40mg IV x 1 - 30 minute						
	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 p	prior to infusion					
Other:						
Medication: Below products are specific to insurance approval						
Osteoporosis / Paget Disease : Reclast (zoledronic ac	cid) 5mg/100mL IV x 1 dose - Administer over 30 minutes					
Oncologic Use: Zometa (zoledronic acid) 4mg / 100mL IV ac	Iministered over 30 minutes.					
Frequency:						
Recent Labs: Cr Ca	Albumin					
F INFUSION-RELATED REACTION OCCURS (FOR ALL ORDER	(S):					
	Iminister PRN medications per infusion reaction medications					
1. STOP infusion listed	below					
2. Alert rapid response team (if clinically indicated) 5. Notify Physician						
	tal 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						
Epinephrine 0.3mg IM x 1 as needed for anaphylaxis Methylprednisolone Succinate 125mg IV x 1 as needed for anaphylaxis						
NURSING ORDERS						
Ensure a recent Serum Creatine BUN, Calcium and alb	oumin have been done prior to treatment.					
 Nurse will obtain current height and weight and report values to pharmacy. 						
 Hold infusion and call MD if: (Contraindicated) 	Osteoporosis / Pages: CrCL < 35 mL/mn					
	Oncologic Use: ScCL <60 mL/min					
 This medication is hazardous - please use proper pre 	cautions.					
• Monitor patient for 30 minutes after infusion complete.						
 Flush line with 10mL 0.9% Sodium Chloride 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 10Hz post infusion, followed by rieparm 300 units (if applicable) Use PICC line, flush with NS 10mL post infusion with 0.9% NS (if applicable) 						
Discharge when criteria met						
	Time:					
Qualified Medical Provider Name (Print) :						
Signature: N	PI#: #### ## ## ## ## ## ## #					