Outpatient Infusion/Injection Order

Patient Name: _____ DOB: _____

Ht (cm): _____ Wt (kg): _____ Allergies: _____

_____

Diagnosis Code: _____ Diagnosis: _____

Code Status: _____

Provider Name (PRINT First and Last): _____

Provider Office Phone # _____ Provider Office Fax # _____

Medication: _____

Reason: _____

Dose: _____ Rate: _____ Route: ☐ IV ☐ IM ☐ SQ

Frequency: _____

Premedication (if required):

☐ acetaminophen 650mg PO once
☐ diphenhydrAMINE 25mg PO once
☐ famotidine 20mg PO once
☐ dexAMETHasone _____mg PO once
☐ methylprednisolone _____mg IV push once
☐ acetaminophen 1000mg once
☐ diphenhydrAMINE 25mg IV push once
☐ ondansetron 4 mg IV push once
☐ dexAMETHasone _____mg IV push once
☐ Other _____ Route _____ once

All medication orders MUST include route of administration.

Treatments:

☐ May use vascular access device. After use, flush with 10mL preservative-free saline and lock with:

☐ Preservative-free normal saline solution 10mL IV push once or

☐ Heparin (10 units/mL) 10mL IV push once

Date: _____ Provider Signature:_____