Three Rivers HEALTH

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: _____

Biosimilar options may be substituted unless otherwise indicated. ☐ Dispense as written

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

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

If Labs required:

Labs to obtain: _____

Frequency: _____ Start Date: _____ Stop Date/ # of Occurrences: _____

Result Instructions: ☐ Fax to Provider ☐ Call critical results to Provider

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PROVIDER SIGNATURE: _____ Date: _____ Time: _____