TriState Health

INFUSION ORDER FORM

Patient Name* _____ Date of Birth* ____/____/_____

Patient Address _____ Patient Phone #* _____

Treatment*_____

Frequency _____ Duration* _____ Route* IV ____ PO ____ Other _____

Treatment*_____

Frequency _____ Duration* _____ Route* IV ____ PO ____ Other _____

DX* _____ Labs _____ Frequency _____

Additional Tests _____ Frequency _____

If blood tranfusion ordered:

- ❑ Physician and patient discussed the transfusion's purpose, risks, benefits, and alternatives before the order was created (If this box is left unchecked when blood is ordered, the order is not valid and will be sent back)

Do you have history of MDRO/VRE? ❑ Yes ❑ No

Have you been tested for COVID-19? ❑ Yes ❑ No Date Tested____/____/_____ Results ❑ Positive ❑ Negative

Procedure Code(s) _____ Diagnosis Code(s)* _____

Primary Care Provider _____

If allergic reaction occurs:

- ❑ Diphenhydramine 25 mg PO/IV PRN itching, SOB, may repeat if symptoms do not improve
- ❑ Solu-Medrol 40 mg IV PRN itching, rash, SOB (or other signs of infusion reaction)
- ❑ Epinephrine (1: 1000) 0.3-0.5 mg SQ/IM PRN for anaphylaxis and call
- ❑ O2 2-6 L/minute PRN SOB or chest pain
- ❑ Notify Provider of systolic BP <100, pulse > 100, or temp > 101 degrees F or other concerns

_____ _____ Date ____/____/_____

Print Name of Physician* Physician Signature*

TRISTATE OUTPATIENT SERVICES

PHONE: 509.758.4663

FAX: 509.751.0236

**All sections marked MUST be completed or the order form will be returned.*