ChristianaCare™

DOCORD

DOCTOR'S ORDER SHEET
DEPARTMENT OF INFUSION SERVICES
INTRAVENOUS IMMUNE GLOBULIN

Instructions:
1. Do not return charts with new or changed orders to rack.
2. Mark requested orders and/or boxes if indicated.

• Pre-marked box orders will be performed unless otherwise noted.
• No conditional (dependent on the approval of another physician) medication orders will be honored.

DOCTOR'S ORDER	REQUISITIONED	NOTED

This order form is not valid for prescribing of controlled substances

Instructions: Fax the below information

1. Completed and signed doctor's order sheet form (please include all pages)
2. Patient demographics including insurance information
3. Once all items are reviewed ChristianaCare Infusion Services will reach out to your patient to schedule

- **Phone:** 302-733-1548
- **Access coordinator:** 302-733-1553
- **Fax:** 302-733-1561

☐ New Referral
☐ Order Renewal
☐ Medication/Order Change

Date: _____ /_____ /_____
Patient name:
DOB: _____ /_____ /_____
Allergies:
Weight [kg or lb (mark one)]: _____ Date: ____ /____ /____
ICD 10:

☐ Insurance Authorization/Prior Auth number: _____

☐ If no insurance authorization needed provide confirmation/reference number: _____

1) **Pre-Medications:**
   A. ☐ Acetaminophen (e.g. Tylenol®) 650 mg PO once 30 minutes prior to infusion
   B. ☐ DiphenhydrAMINE (e.g. Benadryl®) 50 mg PO once 30 minutes prior to infusion
   C. ☐ Hydrocortisone (e.g. Solu-CORTEF®) _____ mg IV once 30 minutes prior to infusion
      OR
      ☐ MethylPREDNISolone (e.g. SOLU-Medrol®) _____ mg IV once 30 minutes prior to infusion
   D. ☐ Hydration: _____ mL NS infused over _____ minutes Pre/Post/Concurrent (mark as needed) to IVIG infusion
   E. ☐ Other (must include medication, dose, route and frequency): _____
      _____

2) **IVIG (e.g.Privigen®)** brand will be dispensed unless otherwise specified: _____
   (please ensure prior auth matches product to be dispensed)
   Dosing:
   ☐ Weight based dose: _____ g/kg/day IV x _____ days every _____ weeks
   ☐ Weight based dose: Total dose _____ g/kg IV divided over _____ days every _____ weeks
   ☐ Flat dose: _____ grams IV once every _____ weeks
   ☐ Flat dose: _____ grams IV divided over _____ days every _____ weeks
   Duration of order: ☐ 6 months OR _____ total doses
   orders will be honored for a max of 6 months

_____ _____
Signature/Title Contact phone #

_____ _____/_____/_____ _____
Print Name or ID# Date Time

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Key:

BID - Twice daily
D5W - Dextrose 5% in water solution
D/C - Discontinue
DOB - Date of birth
HOH - Hard of hearing
hr - Hour
ICD - International Classification of Diseases
IM - Intramuscular
IV - Intravenous
IVIG - Intravenous immune globulin
kg - Kilogram
L - Left
LD - Loading dose
LR - Lactated ringers
mcg - Microgram
MD - Maintenance dose
mg - Milligram
min - Minute
mL - Milliliter
ng - Nanogram
NPO - Nothing by mouth
NS - 0.9% sodium chloride
NSS - Normal saline solution
PCA - Patient controlled analgesia
PO - By mouth
PRN - As needed
R - Right
TID - Three times daily
X - Times

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DOCTOR'S ORDER	REQUISITIONED	NOTED
☐ Other (must include medication, dose, route, frequency and duration): _____		
Note: For weight-based dosing pharmacist will dose based on ideal body weight (IBW) unless the patient's actual body weight (ABW) is less than the IBW or the patient's ABW is > 120% of IBW. If ABW is > 120% IBW, then adjusted body weight will be used. Adjusted body weight = IBW + 0.4 (ABW-IBW). Pharmacist to round doses to increments of 5 g.		
3) **Additional orders:** _____		
_____		
_____		
_____		

_____ _____
Signature/Title Contact phone #

_____ _____/_____/_____ _____
Print Name or ID# Date Time