SOMC Cancer Center & Infusion
Ph: (740) 356-7490
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Cyanocobalamin (Vitamin B12) Order Form

PATIENT & PRESCRIBER INFORMATION

Patient Name: _____ DOB: _____ Phone: (H) _____ (C) _____

Patient Address: _____

Ht.: _____ Wt.: _____ ☐lbs. ☐kg. Allergies: _____

Prescriber Name/Title: _____ Address: _____

Phone: _____ Fax: _____ Prescriber NPI #: _____

REQUIRED: **Most Recent H&P, clinical notes, & medication list are required unless the patient is established with SOMC. Supporting clinical notes should include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

DIAGNOSIS, CLINICAL INFORMATION, & PRESCRIPTION

☒ **May substitute mandated or preferred biosimilar as necessary.**

☒ **Infusion rates will follow manufacturer recommendations.**

☒ **In the event of an adverse reaction, line maintenance/flushes, or O2 are required, the SOMC AIC established protocols will be utilized.**

AND

Diagnosis (Check all that apply)

☒Vitamin B12 Deficiency

Dose:

Initial Dose:

☐ Vitamin B12 IM injection 1,000 mcg every day times _____ days, then

☐ Vitamin B12 IM injection 1,000 mcg every week times _____ weeks.

Maintenance Dose:

☐ Vitamin B12 IM injection 1,000 mcg every month (Q28D) times _____ months.

☐ Vitamin B12 IM injection 1,000 mcg every 28 days x 1 year.

Additional order(s)_____

Lab order(s)

☐ **CBC**	☐ **at each dose**	**or**	☐ **every** _____
☐ **CBC w/ Diff**	☐ **at each dose**	**or**	☐ **every** _____
☐ **CMP**	☐ **at each dose**	**or**	☐ **every** _____

☐ **Other –** _____

PROVIDER:	**DATE:**	**TIME:**	**SIGNATURE:**

Southern Ohio Medical Center
Very Good things are happening here

CYANO

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