General Infusion Order Form

SOMC Cancer Center & Infusion
Ph: (740) 356-7490
Fx: (740) 356-7488

Please do not use this if there is a more specific form available.
For therapies not listed on our website, please use this 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 Infusion established protocols will be utilized.**

☒ **0.9% NaCl 250 ml primary at KVO during infusion and for line flushing**

Pre-Treatment Options: (Check all that apply) **To be administered 30 minutes prior to each administration.**

☐ Acetaminophen (Tylenol) 650 mg by mouth x 1 dose

☐ 25 mg / ☐ 50 mg Diphenhydramine (Benadryl) ☐ PO or ☐ IV x 1 dose

☐ Methylprednisolone (Solumedrol) 100 mg IVP x 1 dose

☐ Hydrocortisone 100 mg IVP x 1 dose prior to treatment

☐ Other (**Please Specify**) – _____

AND

Diagnosis Description: _____

Medication to Order: _____

Dose: _____

Route: _____

Frequency: _____

Duration: _____

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

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