Defaults for orders not otherwise specified below:

- Interval: Once
- Interval: Every ______ days

### Duration:
- Until date: __________
- 1 year
- ______ # of Treatments

### Anticipated Infusion Date__________

<table>
<thead>
<tr>
<th>ICD 10 Code with Description</th>
<th>__________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height (cm)</td>
<td>Weight (kg)</td>
</tr>
</tbody>
</table>

#### Provider Specialty

- [ ] Allergy/Immunology
- [ ] Cardiology
- [ ] Gastroenterology
- [ ] Genetics

#### Site of Service

- [ ] SH Gerber
- [ ] SH Lemmen Holton (GR)
- [ ] SH Pennock
- [ ] SH Ludington
- [ ] SH Reed City
- [ ] SH Zeeland

### Appointment Requests

- [ ] Infusion Appointment Request
  - Status: Future, Expected: S, Expires: S+366, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Infusion

### Provider Reminder

- [ ] ONC PROVIDER REMINDER 14
  - Pretreatment with acetaminophen and an antihistamine is recommended. For symptoms of allergic reaction or anaphylaxis, order "Peds Hypersensitivity Reactions" Therapy Plan.

### Lab Orders

<table>
<thead>
<tr>
<th>Interval</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Every ___days</td>
<td>Until date: __________</td>
</tr>
<tr>
<td>Once</td>
<td>1 year</td>
</tr>
</tbody>
</table>

### Hydration

- [ ] dextrose 5% and sodium chloride 0.45% infusion
  - Dose:
    - [ ] 50 mL/hr
    - [ ] 75 mL/hr
    - [ ] 100 mL/hr
    - [ ] 125 mL/hr
  - For:
    - [ ] _____ hours

  Intravenous, Continuous, Starting S, For 1 Days

CONTINUED ON PAGE 2 ➤
Pre-Medications – SELECT DOSE FORM

Select Acetaminophen Tablet OR Suspension

☐ acetaminophen (TYLENOL) tablet 15 mg/kg (Treatment Plan) Max Dose of 650mg
15 mg/kg, Oral, Once, Starting S, For 1 Doses
Administer 30 minutes prior to infusion.
No more than 5 doses from all sources in 24 hour period, not to exceed 4000 mg/day

☐ acetaminophen (TYLENOL) 32 MG/ML suspension 15 mg/kg (Treatment Plan) Max Dose of 650mg
15 mg/kg, Oral, Once, Starting S, For 1 Doses
Administer 30 minutes prior to infusion.
No more than 5 doses from all sources in 24 hour period, not to exceed 4000 mg/day

Select Diphenhydramine Capsule, Injection OR Elixir

☐ diphenhydrAMINE (BENADRYL) injection 1 mg/kg (Treatment Plan) Max Dose of 50mg
1 mg/kg, Intravenous, Once, Starting S, For 1 Doses
Administer 30 minutes prior to infusion.
Recommended maximum single dose is 50mg

☐ diphenhydramINE (BENADRYL) capsule 1 mg/kg (Treatment Plan) Max Dose of 50mg
1 mg/kg, Oral, Once, Starting S, For 1 Doses
Administer 30 minutes prior to infusion.
Recommended maximum single dose is 50mg

☐ diphenhydrAMINE (BENADRYL) 12.5 MG/5ML elixir 1 mg/kg (Treatment Plan) Max Dose of 50mg
1 mg/kg, Oral, Once, Starting S, For 1 Doses
Administer 30 minutes prior to infusion.
Recommended maximum single dose is 50mg

☐ Pre-medication with dose: ______________________________________________________________________

☐ Pre-medication with dose: ______________________________________________________________________

Medications

☐ cytomegalovirus immune globulin (CYTOGAM) infusion
Dose:
☐ 50mg/kg
☐ 100mg/kg
☐ 150mg/kg
☐ 200mg/kg
☐ 400mg/kg

Intravenous, Titrate, Starting S+30 Minutes, For 1 Doses
Infuse through a 0.2-15 micron in-line filter. Begin infusion rate at ___ mL/hr (0.3 mL/kg/hr), if tolerated, may double infusion rate every 30 minutes to a maximum rate of ___ mL/hr (1.2 mL/kg/hr)

Nursing Orders

☐ ONC NURSING COMMUNICATION 1
- Monitor temperature, blood pressure, heart rate, respiratory rate and oxygen saturation prior to infusion and then every 15 minutes x 2, then every 30 minutes x 1, then hourly x 2, then every 2 hours for the duration of the infusion. If any signs or symptoms of an infusion related reaction occur, vital signs should be checked immediately.
- Notify provider if O2 saturation is less than or equal to 92%
- Notify provider if patient has itching, hives, swelling, fever, chills, rigor, dyspnea, or a greater than 20% decrease in systolic blood pressure from baseline.
- Verify that patient has diphenhydramine / Epi-pen available (as appropriate) for immediate home use. Advise patient that severe hypersensitivity or anaphylactic reactions may occur during and after infusion. Inform patients of signs and symptoms of anaphylaxis and hypersensitivity reactions, and importance of seeking medical care.

Telephone order/Verbal order documented and read-back completed. Practitioner’s initials ____________

NOTE: Unless Order is written DAW (dispense as written), medication may be supplied which is a generic equivalent by nonproprietary name.

<table>
<thead>
<tr>
<th>TRANSCRIBED:</th>
<th>VALIDATED:</th>
<th>ORDERED:</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIME</td>
<td>DATE</td>
<td>TIME</td>
</tr>
<tr>
<td>Sign</td>
<td>R.N. Sign</td>
<td>Physician Print</td>
</tr>
</tbody>
</table>