Defaults for orders not otherwise specified below:
- Interval: Once
- Interval: Every _____ days

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

Anticipated Infusion Date___________ ICD 10 Code with Description__________________________
Height____________________(cm) Weight______________(kg) Allergies______________________________

Site of Service
- [ ] SH Gerber
- [ ] SH Lemmen Holton (GR)
- [ ] SH Pennock
- [ ] SH United Memorial
- [ ] SH Helen DeVos (GR)
- [ ] SH Ludington
- [ ] SH Reed City
- [ ] SH Zeeland

Provider Specialty
- [ ] Allergy/Immunology
- [ ] Infectious Disease
- [ ] OB/GYN
- [ ] Rheumatology
- [ ] Cardiology
- [ ] Internal Med/Family Practice
- [ ] Other
- [ ] Surgery
- [ ] Gastroenterology
- [ ] Nephrology
- [ ] Otolaryngology
- [ ] Urology
- [ ] Genetics
- [ ] Neurology
- [ ] Pulmonary
- [ ] Wound Care

Appointment Requests
- [ ] Infusion Appointment Request
  Status: Future, Expected: S, Expires: S+365, Sched. Tolerance: Schedule appointment at most 3 days before or afterInfusion and possible labs

Nursing Orders
- [ ] ONC NURSING COMMUNICATION 100
  May Initiate IV Catheter Patency Adult Protocol

Vitals
- [ ] Vital Signs
  Routine, PRN, Starting S, Take vital signs at initiation and completion of infusion and as frequently as indicated by patient’s symptoms

Labs
- [ ] Complete Blood Count w/Differential
- [ ] Basic Metabolic Panel (BMP)
- [ ] Comprehensive Metabolic Panel (CMP)
- [ ] C Reactive Protein (CRP), Blood Level
- [ ] Creatine Kinase (CK) Level

CONTINUED ON PAGE 2 ➔

NOTE: Epic Treatment/Therapy Plan Orders. To be scanned/attached to the appropriate Infusion Referral Order in Epic.
Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

### MICAFUNGIN (MYCAMINE) - ADULT, OUTPATIENT, INFUSION CENTER (CONTINUED)

**Patient Name**

**DOB**

**MRN**

**Physician**

**FIN**

<table>
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<td>☐ Sedimentation rate</td>
<td>☐ Once</td>
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#### Additional Lab Orders

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<td>☐ Until date: ______</td>
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<tr>
<td>☐</td>
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<td>☐ 1 year</td>
</tr>
<tr>
<td>☐</td>
<td>☐ ____ # of Treatments</td>
<td></td>
</tr>
</tbody>
</table>

#### Medications

- ☑ micafungin (MYCAMINE) IVPB
  - Dose:
    - ☐ 50 mg
    - ☐ 100 mg
    - ☐ 150 mg
    - ☐ ____ mg

Intravenous, Administer over 1 Hour, Once, Starting S, For 1 Dose
Do not mix or infuse with other products. Flush line with NS prior to administration.

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.

**EPIC VERSION DATE:** 7/16/20