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.

### Physician's Orders
**PENTAMIDINE, INTRAVENOUS - PEDIATRIC, OUTPATIENT, INFUSION CENTER**

Default for orders not otherwise specified below:
- Interval: Every 21 days
- Interval: Every ___ days

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

Anticipated Infusion Date __________ ICD 10 Code with Description________________________

Height __________ (cm) Weight __________ (kg) Allergies________________________

### 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

### 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

### Appointment Requests
- ☑ Infusion Appointment Request
  - Status: Future, Expected: S, Expires: S+365, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Infusion

### Lab Orders

<table>
<thead>
<tr>
<th>Labs:</th>
<th>Interval</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Every ___ days</td>
<td>□ Until date: __________</td>
</tr>
<tr>
<td></td>
<td>□ Once</td>
<td>□ 1 year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ ______# of Treatments</td>
</tr>
</tbody>
</table>

### Pre-Medications

**Ondansetron Premed-select Injection Or ODT**

- □ ondansetron (ZOFTRAN) IV 0.15 mg/kg (Treatment Plan) Max Dose of 4mg
  - 0.15 mg/kg, Intravenous, Administer over 5 Minutes, Once, Starting S, For 1 Dose
  - Give 30 to 60 minutes prior to infusion.
  - Recommended maximum single dose is 16 mg

- □ ondansetron (ZOFTRAN-ODT) disintegrating tab 0.15 mg/kg (Treatment Plan) Max Dose of 4mg
  - 0.15 mg/kg, Oral, Once, Starting S, For 1 Dose
  - Give 30 to 60 minutes prior to infusion.
  - Recommended maximum single dose is 16 mg

### Additional Pre-Medications

- □ Pre-medication with dose: ______________________________
  ______________________________

- □ Pre-medication with dose: ______________________________

**CONTINUED ON PAGE 2 ➔**

**NOTE:** Epic Treatment/Therapy Plan Orders. To be scanned/attached to the appropriate Infusion Referral Order in Epic.
Medications

☑ pentamidine 2 mg/mL in D5W (PENTAM) IV syringe 4 mg/kg
4 mg/kg, Intravenous, Administer over 90 Minutes, Once, Starting S+30 Minutes, For 1 Dose
Protect from light. PCP prophylaxis

Vitals

☑ Vital Signs Routine, PRN, Starting S, Document vitals pre and post treatment with inhaled pentamidine.

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.