Spectrum Health Helen DeVos children's hospital

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

Patient Name
DOB
MRN
Physician
FIN

Defaults 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+366, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Infusion

Lab Orders

☐	Labs: _____	☐ Every ___days ☐ Once	☐ Until date: _____ ☐ 1 year ☐ _____# of Treatments
☐	Labs: _____	☐ Every ___days ☐ Once	☐ Until date: _____ ☐ 1 year ☐ _____# of Treatments

Pre-Medications

Ondansetron Premed-select Injection Or ODT

☐ ondansetron (ZOFRAN) IV 0.15 mg/kg (Treatment Plan) Max Dose of 4mg
0.15 mg/kg, Intravenous, for 5 Minutes, Once, Starting H, For 1 Doses
Give 30 to 60 minutes prior to infusion.
Recommended maximum single dose is 16 mg

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

CONTINUED ON PAGE 2 ➔

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

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PENTAMIDINE, INTRAVENOUS - PEDIATRIC, OUTPATIENT, INFUSION CENTER *(CONTINUED)*

Patient Name

DOB

MRN

Physician

FIN

Additional Pre-Medications

☐ Pre-medication with dose:
_____

☐ Pre-medication with dose:
_____

Medications

☑ pentamidine 2 mg/mL in D5W (PENTAM) IV syringe 4 mg/kg
(Treatment Plan)
4 mg/kg, Intravenous, for 90 Minutes, Once, Starting H+30 Minutes, For 1 Doses
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.

TRANSCRIBED:		**VALIDATED:**		**ORDERED:**		
TIME	**DATE**	**TIME**	**DATE**	**TIME**	**DATE**	Pager #
	Sign		**R.N. Sign**		**Physician Print**	**Physician**

EPIC VERSION DATE: 07/16/20

