STAT ☐

Status:

DOB: Age:

Name:
Ref Phys:
Att Phys:
Prim Care Phys:

PATIENT NAME:	OFFICE PHONE #:
PATIENT PHONE #:	OFFICE FAX #:
ORDERING PROVIDER:	PATIENT DOB:
NURSE/MA:	PRIOR AUTH OBTAINED: Yes No
PATIENT ALLERGIES:	PRIOR AUTH #: (*required*)
LABS TO BE DRAWN:	DIAGNOSIS/ICD-10 CODE: *(required)*

MEDICATION NAME: (*see attached formulary*)	FREQUENCY:
DOSE:	# OF INFUSIONS/DURATION:
ROUTE:	FIRST TIME DOSE ?: Yes No

Acetaminophen PO Pre-Med: (30 min before infusion)			325mg	500mg	650mg 1000mg
Diphenhydramine Pre-Med: (30 min before infusion)	PO	IV			25mg 50mg
Methylprednisolone IV Pre-Med: (30 min before infusion)					40mg 125mg
Ondansetron IV PRN indication (*required*):					4mg q6 hours
Other Medications Ordered: (drug name, route, dose, and indication)					

PERTINENT PATIENT INFORMATION:

☐ I authorize use of the Community Hospital Adult Hypersensitivity Reaction/Anaphylaxis Protocol

Provider's Signature: _____ Date: _____

order expires one year from written date

form updated 11/14/19