



Outpatient Procedure Orders
GCH Outpatient contact Information:
Phone: 802-365-5347 Fax: 802-365-3947

Patient Name: _____ DOB: _____
Height: _____ Weight: _____ Allergies: _____
Current Medications: _____
Ordering Provider: _____
Provider Signature: _____ Date: _____
Phone: _____ Fax: _____ NPI: _____

In the event of an infusion reaction, turn off infusion, initiate anaphylaxis protocol. Notify Prescriber.
Ordering Provider Initials _____

Prior Auth:
(required)
 Prior Authorization Required (circle one) **Y/N** Ref# _____ PA _____ Exp date: _____

Lab Orders:

Access In Place:
(Please send information)
 PICC Line **Y/N if Yes please include placement Procedure note**
 Port **Y/N if Yes please include Port Details**

Pre-Medication:
(Please select)
 Diphenhydramine 25mg: (circle one) **IV / PO** once prior to infusion
 Acetaminophen 650mg PO once prior to infusion
 Famotidine 20mg once prior to infusion (circle one) **IV / PO**
 Methylprednisolone 125mg IV push once prior to infusion

PRN Medications:
(Please select)
 Diphenhydramine 25mg PO once PRN during infusion for signs of medication reaction
 Acetaminophen 650mg PO q4hr PRN pain and/or fever
 Toradol 15mg IV once PRN headache
 None

Hydration:
(Please select)
 Normal saline 0.9% 500mL bolus over 30 minutes prior to and/or after infusion PRN for hydration and/or headache. Maximum: 1,000mL per infusion

Post Medication:

Intravenous Outpatient Procedures:

(Please select)

Medication	Dose	Route/Rate	Frequency	Duration	Diagnosis
Denosumab <input type="checkbox"/> Prolia	<input type="checkbox"/> 60mg	<input type="checkbox"/> SubQ	<input type="checkbox"/> q6months	<input type="checkbox"/> Once	<input type="checkbox"/> Osteoporosis <input type="checkbox"/> ICD 10 _____
Epoetin Alfa <input type="checkbox"/> Retacrit	<input type="checkbox"/> _____ Units	<input type="checkbox"/> SubQ	<input type="checkbox"/> q____week(s) <input type="checkbox"/> _____	<input type="checkbox"/> _____ doses	<input type="checkbox"/> Anemia <input type="checkbox"/> ICD 10 _____
Iron Sucrose <input type="checkbox"/> Venofer	<input type="checkbox"/> 100mg <input type="checkbox"/> 200mg <input type="checkbox"/> 300mg	<input type="checkbox"/> IV piggyback over 30 minutes -1.5 hours <input type="checkbox"/> IV push (≤200mg doses)	<input type="checkbox"/> qWeek <input type="checkbox"/> _____	<input type="checkbox"/> _____ doses	<input type="checkbox"/> Iron Deficiency Anemia <input type="checkbox"/> ICD 10 _____
Ferumoxytol <input type="checkbox"/> Feraheme	<input type="checkbox"/> 510mg x 2 doses <input type="checkbox"/> _____	<input type="checkbox"/> IV piggyback over 30 minutes	<input type="checkbox"/> Once <input type="checkbox"/> qWeek	<input type="checkbox"/> Single dose infusion <input type="checkbox"/> Two dose infusion <input type="checkbox"/> _____	<input type="checkbox"/> Iron Deficiency Anemia <input type="checkbox"/> ICD 10 _____
IVIG <input type="checkbox"/> Privigen	<input type="checkbox"/> Loading dose: _____ <input type="checkbox"/> Maintenance dose: _____	<input type="checkbox"/> IV Rate per IVIG policy <input type="checkbox"/> Personalized rate per provider: _____	<input type="checkbox"/> Loading dose: _____ <input type="checkbox"/> Maintenance dose: _____	<input type="checkbox"/> _____	<input type="checkbox"/> CIDP <input type="checkbox"/> ICD 10 _____
Normal Saline <input type="checkbox"/> 0.9% NaCl	<input type="checkbox"/> 250mL <input type="checkbox"/> 500mL <input type="checkbox"/> 1000mL	<input type="checkbox"/> IV	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> Dehydration <input type="checkbox"/> ICD 10 _____
Zoledronic Acid <input type="checkbox"/> Reclast	<input type="checkbox"/> 5mg	<input type="checkbox"/> IV over 30 minutes	<input type="checkbox"/> Once	<input type="checkbox"/> Once	<input type="checkbox"/> Osteoporosis <input type="checkbox"/> ICD 10 _____
Ceftriaxone <input type="checkbox"/>	<input type="checkbox"/> 1gm <input type="checkbox"/> 2gm	<input type="checkbox"/> IV <input type="checkbox"/> IM	<input type="checkbox"/> Q24hr <input type="checkbox"/> _____	<input type="checkbox"/> _____ <input type="checkbox"/> Stop date _____	<input type="checkbox"/> ICD 10 _____



Intravenous Outpatient Procedures:

(Please select)

Medication	Dose	Route/Rate	Frequency	Duration	Diagnosis
Leuprolide <input type="checkbox"/> Lupron	<input type="checkbox"/> ____mg	<input type="checkbox"/> IM <input type="checkbox"/> subQ	<input type="checkbox"/> ____	<input type="checkbox"/> ____	<input type="checkbox"/> ICD 10 ____
Remdesivir <input type="checkbox"/> Veklury	<input type="checkbox"/> 200mg x 1 then 100mg on days 2 and 3	<input type="checkbox"/> IV <input type="checkbox"/> piggyback over 30-120minutes	<input type="checkbox"/> daily	<input type="checkbox"/> 3 days(s) <input type="checkbox"/> ____ dose(s)	<input type="checkbox"/> COVID-19 treatment
Other <input type="checkbox"/>					

Other Outpatient Procedures:

(Please select)

Procedure	Frequency	Diagnosis	Order Instructions:
ECG	<input type="checkbox"/> Once	<input type="checkbox"/> ICD 10 ____	<input type="checkbox"/> N/A <input type="checkbox"/> ____
Port DE Access	<input type="checkbox"/> ____	<input type="checkbox"/> ICD 10 ____	<input type="checkbox"/> Saline Flush ____ <input type="checkbox"/> Heparin Flush ____ <input type="checkbox"/> ____
Foley Change	<input type="checkbox"/> ____	<input type="checkbox"/> ICD 10 ____	<input type="checkbox"/> N/A <input type="checkbox"/> ____
PICC Line Dressing Change	<input type="checkbox"/> ____	<input type="checkbox"/> ICD 10 ____	<input type="checkbox"/> ____
Other <input type="checkbox"/>			