GraceCottage
FAMILY HEALTH & HOSPITAL

Outpatient Procedure Orders
GCH Outpatient contact Information:
Phone: 802-365-3695 Fax: 802-365-3647

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:

☐ _____

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Intravenous Outpatient Procedures:

(Please select)

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

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Intravenous Outpatient Procedures:

(Please select)

Medication	Dose	Route/Rate	Frequency	Duration	Diagnosis
Leuprolide ☐ Lupron	☐ _____mg	☐ IM ☐ subQ	☐ _____	☐ _____	☐ ICD 10 _____
Remdesivir ☐ Veklury	☐ 200mg x 1 then100mg on days 2 and 3	☐ IV ☐ piggyback over 30-120minutes	☐ daily	☐ 3 days(s) ☐ _____ dose(s)	☐ COVID-19 treatment
Other ☐					

Other Outpatient Procedures:

(Please select)

Procedure	Frequency	Diagnosis	Order Instructions:
ECG	❑ Once	☐ ICD 10 _____	❑ N/A ❑ _____
Port DE Access	❑ _____	❑ ICD 10 _____	❑ Saline Flush _____ ❑ Heparin Flush _____ ❑ _____
Foley Change	❑ _____	❑ ICD 10_____	❑ N/A ❑ _____
PICC Line Dressing Change	❑ _____	❑ ICD 10_____	❑ _____
Other ☐			