

Insurance Verification

Name: John Shannon DOB: 11/19/37 MR# 1001047
 Ins. ID # 942010947
 Phone#: 877-842-3210
 Date: 9/26/17 Time: 1:20pm DX: _____
 Eff Date: 11/1/17
 Copay: \$ Copay DED: \$
 Percent: 20% of Res. OOP: 4000 Cop max 100% covered
 Name of Person: Steven
 REF: 0793
 Jcode: J0844

Auth Req'd YES: _____ NO: ✓
 Auth# _____ Date Span: _____
 Phone: _____ Fax: _____
 Name: _____

Can we Buy and Bill:

YES: _____ NO: _____

Specialty Pharmacy: _____
 Phone#: _____ Fax: _____

OUTPATIENT INFUSION CENTER
ORANGE REGIONAL MEDICAL CENTER
NEW PATIENT INTAKE FORM
(MUST BE USED EVERYTIME A NEW PATIENT IS TO BE SCHEDULED)

NAME: JOHN SHANNONDOB: 1/19/32PT'S PHONE #: 845-856-3095PROCEDURE: Decitabine 15 dayDURATION: 3 hoursDIAGNOSIS: MDSNAME OF PERSON TALKED TOO: Dr. KamrathPHYSIAN & PHONE: 333-3626

INSURANCE: _____

ALLERGIES: None

IMMEDIATELY AFTER MAKING THE APPOINTMENT, FAX THIS FORM AND COPY OF
SCRIPT FOR AUTHORIZATION AND PRE-REGISTRATION PROCESS: EXT 1715

*PLEASE SEND A COPY TO PHARMACY IF PATIENT IS TO RECEIVE CHEMOTHERAPY:
EXT 1124

STACY BUDD
PHONE: (845) 333-1905
FAX: (845) 333-1902

ALLISON ROCHE
PHONE: (845) 333-1906
FAX: (845) 333-1902

John Sherman



CHEMOTHERAPY ORDERS

Patient Label

TO BE COMPLETED BY PHYSICIAN:			Patient Name:		DOB: 1.19.37		
Date Written: 9-26-17			Date of Administration:				
Diagnosis: - Acute Myeloid			TNM Stage:		Allergies: <input checked="" type="checkbox"/> NKDA		
Protocol / Regimen - HDS. Leukemia cycle 1 of 6 Decitabine.			Day				
Venous Access: <input type="radio"/> Peripheral <input type="radio"/> Central							
Height	Weight	<input checked="" type="radio"/> Actual <input type="radio"/> Ideal <input type="radio"/> Adjusted <input type="radio"/> Dosing	Body Surface Area (m ²)	Emetic Level <input checked="" type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> High			
5 ft 5 in	134.2 kg 165 lbs		1.67				
Lab Orders:		<input checked="" type="checkbox"/> CBC/DIFF	<input checked="" type="checkbox"/> BMP	Magnesium	<input checked="" type="checkbox"/> UA On day 1 of each cycle		
Hold Parameters: ANC less than: 1.5 WBC less than: 2.5 PLT less than: 50 Hgb/Hct less than: 7.5 / SCr greater than: 1.5							
Non-chemotherapy orders:				RPh initials / Nurse Initials			
<input checked="" type="checkbox"/> IV Fluids: NS @ KVO (20 mL/hr)							
- Zofran 4mg IV x1 day 1-5.							
- Weekly Labs - CBC/diff, BMP.							
Solution, volume and infusion rate are per manufacturer/hospital guidelines unless otherwise specified. Chemotherapeutic agents will be rounded down to nearest vial size if within 5% of calculated dose. Biological agents will be rounded down to the nearest vial size if within 10% of calculated dose. Please administer chemotherapy in sequence listed below.							
Chemotherapy	Dose per Unit (m ² , kg, AUC)	Dose Reduction* (mg/m ² , mg/kg, AUC)	Calculated Dose	Dose Dispensed (Rounding to be completed by RPh)	Route	Infusion Rate	RPh / Nurse initials
Decitabine	20mg/m ²	-	33.00 mg		IV	1 hr day 1-5	
Repeat q	28 days X6.						

*If using a dose reduction, please provide rationale:

MP Name (Print) A. Kaurthau

MD Signature

A. S. Benthon

Date/Time 9-28-17

RN Name (Print)

RN Signature _____

Date/Time _____

RPh Name (Print)

RPh Signature

Date/Time _____

Body Surface Area Calculator (BSA)

Patient Name:

Height:

Weight:

Drug dosage/ M²:

Results

BSA = M²

Dose =

Disclaimer

All calculations must be confirmed before use. The authors make no claims of the accuracy of the information contained herein; and these suggested doses are not a substitute for clinical judgement. Neither GlobalRPh Inc. nor any other party involved in the preparation of this program shall be liable for any special, consequential, or exemplary damages resulting in whole or part from any user's use of or reliance upon this material. PLEASE READ THE DISCLAIMER CAREFULLY BEFORE ACCESSING OR USING THIS SITE. BY ACCESSING OR USING THIS SITE, YOU AGREE TO BE BOUND BY THE TERMS AND CONDITIONS SET FORTH IN THE DISCLAIMER. Read the disclaimer



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Body Surface Area Calculator (BSA)

Patient Name:

Height: weight:

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GREATER HUDSON VALLEY HEALTH SYSTEM
MIDDLETOWN, NEW YORK 10941

DEPARTMENT OF ONCOLOGY - FOLLOWUP NOTE

PATIENT: John Shannon

MEDICAL REC#: 1001047

DATE OF VISIT: 07/07/17

DATE OF BIRTH: 01/19/37

TIME OF VISIT: 11:44 AM

HISTORY OF PRESENT ILLNESS: Mr. Shannon is an 80-year-old white gentleman, a case with myelodysplastic syndrome with refractory cytopenia with multilineage dysplasia, came for followup. He is presently receiving Neulasta every two weeks. It has been giving him some bone pains, but at the same time I have noticed that he has been losing weight. He does not have good appetite. No fever, no night sweats.

PHYSICAL EXAMINATION: Vital Signs: Temperature 98.1, heart rate 95/min regular, respirations 16, blood pressure 119/76, body weight 165 pounds, oxygen saturation 98%. Neck: Supple. No lymphadenopathy. Chest: Clear on auscultation. No axillary lymphadenopathy. Cardiovascular: S1, S2 normal. No murmur or gallop. Abdomen: Soft, nontender. No clinical hepatosplenomegaly. No mass. Extremities: No edema.


LABORATORY DATA: CBC on 07/05/17 showed WBC 1.5, hemoglobin 8.8, hematocrit 28.6, platelet 189,000, neutrophils absolute number was 0.5. He received Neulasta on 07/05/17.

ASSESSMENT AND PLAN:

- Dile A
- R63.4
1. Myelodysplastic syndrome with refractory cytopenia. He will continue Neulasta every two weeks. He states his pain is tolerable. He takes Aleve. I will watch his counts closely. There has not been any infection.
 2. Weight loss which is worrisome to me. I have arranged him to have several blood tests including stool for occult blood and CT scan of chest, abdomen and pelvis. I have explained this to him. He said at times he feels full therefore I have referred him to his GI specialist in Crystal Run Healthcare.

I will see him in two weeks.

Dated: 8.20.17


Arvind G. Kamthan, M.D.

AGK/cze/siv/cbe01
DD: 07/28/17
DT: 07/29/17
00-95166767

PHYSICIAN OFFICE BUILDING

No information on file.

Date/Time: (Not on file) N/A

Hospital Account:

MRN: 1001047

Site: EHS MODEL

Contact Serial #: 8653297

ENCOUNTER

Patient Class:

Unit:

Hospital Service: No service for patient encounter.

Bed:

Admitting Provider:

PCP:

Bowman, Ralph

Attending Provider:

Adm Diagnosis:

PATIENT

Name: SHANNON, JOHN P

DOB: 1/19/1937

Age: 80 y.o.

Address: 29 Pine Street

Sex: Male

City: PORT JERVIS, NY 12771

Language: English

County: ORANGE

Primary Phone: 845-856-3095

Religion: None

Race: White

Ethnicity: Not Hispanic or Latino

EMERGENCY CONTACT

Contact Name

Legal Guardian?

Relationship to Patient

Home Phone

Work

Mobile

1. Shannon, Shirely

Spouse

(845)856-3095

2.

GUARANTOR

Guarantor:

DOB: 1/19/1937

Address:

Sex: Male

Relation to Patient:

Home Phone:

Guarantor ID:

Work Phone:

GUARANTOR EMPLOYER

Employer:

COVERAGE**PRIMARY INSURANCE**

Payor:

Plan: UHC MCR HMO

Address:

Phone:

Subscriber Name:

Subscriber DOB:

Subscriber ID:

Group Number:

Pat. Rel. to Subscriber:

SECONDARY INSURANCE

Payor:

Plan:

Address:

Phone:

Subscriber Name:

Subscriber DOB:

Subscriber ID:

Group Number:

Pat. Rel. to Subscriber:

Contact Serial #: (8653297)

September 26, 2017

Chart ID (No chart ID available)
No chart ID available