UPDATED SCHEDULING SHEET FOR OUTPATIENT MEDICAL

420 Lowell DR., Suite 500 (Professional Tower) 256-265-3058

Scheduler's Name and Phone Number_____

Today's Date/Time_____

Patient's Name_____DOB_____

Ht._____ Wt._____ Allergies_____

Pregnant: No_____ Yes_____ How many weeks_____ Lactating: No_____ Yes_____

Patient's Phone # (C)_____ (H)_____

Social Security #_____

Insurance_____Policy #_____

PCP Referral # _____
(Must have this if patient has Medicaid "Patient First." If MD office does not have this referral #, tell them to get it and fax to us ASAP).

Procedure_____Diagnosis _____

Ordering Physician _____

Date Scheduled_____ Time Scheduled_____

Will this patient's drug be sent to HH from a specialty pharmacy? No_____ Yes_____ If "yes" has the drug order been placed with the specialty pharmacy? No_____ Yes_____

Does pt. have a central line? No_____ Yes_____ What kind: PICC____PortaCath____Hickman_____
Other_____

Is patient ambulatory? Yes_____ No_____ If "no" someone may be asked to stay with patient.

Any special needs? No_____ Yes_____ If "yes" explain_____
Will they need an interpreter? No_____ Yes_____ What language?_____

For All Orders: Make sure physician "signs, dates, and times" all orders. Diagnosis, Ht., Wt., DOB, allergies, and pregnancy and lactation status (if applicable) must be written on order.

For Blood Transfusions: Type & Crossmatch done? Yes_____ No_____ On order sheet include: RBAs discussed with pt. If T & XM done remind them to tell pt. to keep armband on.

If patient is to stay for an extended time remind them to bring lunch or snack if needed.

Instruct Scheduler to fax completed order to (256) 265-3074

PHYSICIAN'S ORDERS

HUNTSVILLE HOSPITAL
HEALTH SYSTEM

PHYORD

HUNTSVILLE, ALABAMA

Plan Selection Display: INF Ferric Carboxymaltose (Injectafer) - NON-Dialysis patients Only
Available at: Outpatient Medical Services

Diagnosis and ICD-10 code _____

Allergies _____

Weight (kg) _____ **Height (cm)** _____

ferric carboxymaltose (Injectafer DoT)

☐ 15 mg/kg, IV Piggyback, Soln-IV, Day of Tx, Administer over: 15 minutes **[Less Than 50 kg]**

☐ 750 mg, IV Piggyback, Soln-IV, Day of Tx, Administer over: 15 minutes **[Greater Than or Equal To 50 kg]**

☐ **Repeat dose in 7 days**

☑ Monitor
T;N, Monitoring
Comments: - Monitor vital signs, including BP, and signs of hypersensitivity reaction q 15 minutes for at least 30 minutes following administration- Observe carefully for signs of adverse reactions including: rash, dizziness, hypotension, hypertension, chest pain, edema, dizziness, headache, constipation, nausea, vomiting, flushing, hypersensitivity reactions

☑ Saline Lock

☐ INF Central and Peripheral Flush Orders OUTPATIENT

☑ Communication Order
T;N, Initiate HOSP Injection or Infusion Reaction and Anaphylaxis (Age > 14) PowerPlan:
Comments: Treatment of Infusion-Related Reaction or Anaphylaxis:

☑ Notify Provider
If patient has:
*Comments: * If patient with active infection, call MD and consider holding IV iron infusion* If patient has a systolic BP >160 mmHg or diastolic BP > 90 mmHg, call MD and consider holding IV iron infusion*If patient has a systolic BP < 90 mmHg or diastolic BP < 60 mmHg, call MD and consider holding IV iron infusion*

☑ Communication Order
T;N, Administer while patient is in a reclined or semi-reclined position.

Physician's Sig: **Trans#:** **Date:** **Time:**

Patient Name:

DOB: