Columbus Community Hospital

Columbus, Nebraska

DOCTORS ORDERS

PLEASE NOTE: Condition of Wound, Removal of Stitches, Consultation, Change in Diagnosis, Complications, Condition on Discharge, Instructions of Patient.

PLEASE SIGN AND DATE EACH ENTRY

PLEASE INDICATE / ALLERGIES

NONE	CODEINE	PENICILLIN	SULFA	ASPIRIN	OTHER	HEIGHT
REACTION						WEIGHT

Authorization is granted to supply medications by non-proprietary name unless checked here ☐

PHYSICIANS ORDERS (including Medications)

Immune Globulin (IVIG) Infusion: **(8/2024)**

Diagnosis Code: ________________________________

Treatment Start Date: ________________ Patient to follow up with provider on date:_____________________

This plan will expire after 365 days at which time a new order will need to be placed

GUIDELINES FOR ORDERING

1. Send **FACE SHEET** and **H&P or most recent chart note.**
2. Pharmacist to round dose to nearest whole vials. Pharmacist to order appropriate combination of vial sizes to administer total ordered dose. For doses that require more than one vial, orders should be prescribed as "once" order(s). For multiple consecutive days: Round dose to administer same dose each day, and set interval to "every visit" (for example, for dose of 70 grams over 2 days, order as 35 grams with "every visit" interval).
3. In patients who may be at risk of renal failure, a decrease in dose, rate, and/or concentration should be considered. IVIG should be given at a rate per CCH pharmacy rate sheet.

LABS: (must check to order)

☐ CBC with Auto Differential, Routine, ONCE, every______ (visit)(days)(weeks)(months) – Circle One
☐ CMP, Routine, ONCE, every______ (visit)(days)(weeks)(months) – Circle One
☐ IGG (serum), Routine, ONCE, every______ (visit)(days)(weeks)(months) – Circle One
☐ Labs already drawn. Date: _________________

NURSING ORDERS:

1. VITAL SIGNS – Assess vital signs before initiating IVIG infusion, at each rate increase, and then hourly after reaching max rate.
2. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

PRE-MEDICATIONS: (Administer 30 minutes prior to infusion)
Note to provider: Please select which medications below, if any, you would like the patient to receive prior to treatment by checking the appropriate box(s)

☐ acetaminophen (TYLENOL) tablet, 650 mg, oral, ONCE, every visit
☐ acetaminophen (TYLENOL) tablet, 975 mg, oral, ONCE, every visit
☐ diphenhydrAMINE (BENADRYL) capsule, 50 mg, oral, ONCE, every visit
☐ diphenhydrAMINE (BENADRYL) inj, 50 mg, IV, ONCE, every visit
☐ loratadine (CLARITIN) tablet, 10 mg oral, ONCE, every visit
☐ famotidine (PEPCID) tablet, 20 mg oral, ONCE, every visit
☐ methylprednisolone (SOLU-MEDROL) inj, 125 mg IV, ONCE, every visit
☐ Other: ____

(cont.)

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PHYSICIANS ORDERS (including Medications)

Immune Globulin (IVIG) Infusion:

MEDICATIONS:

☐ **Privigen 10% (CCH preferred brand)**

(*Pharmacist will round dose to nearest 5-gram vial*)

- ☐ 0.2 g/kg, intravenous, ONCE
- ☐ 0.4 g/kg, intravenous, ONCE
- ☐ 0.5 g/kg, intravenous, ONCE
- ☐ 1 g/kg, intravenous, ONCE
- ☐ __________g, intravenous, ONCE

Interval: (must check one)

- ☐ Once
- ☐ Daily x ______ doses
- ☐ Every week for ______doses

HYPERSENSITIVITY:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop **STOP THE INFUSION**.
2. Obtain vital signs and continue to monitor vitals every 5 minutes.
3. Notify ordering provider.
4. Refer to **Adult Hypersensitivity (HSR) & Allergic Reaction Management** algorithm for assessment guidelines and interventions.
5. Continue to assess as grade of severity may progress.
6. Administer emergency medications as directed on the physician's orders.

HYPERSENSITIVITY MEDICATIONS:

- **Acetaminophen**, **975 mg**, PO, x 1 dose, AS NEEDED for hypersensitivity or infusion reaction.
- **DiphenhydrAMINE inj, 50 mg**, IV, AS NEEDED for hypersensitivity or infusion reaction. May repeat x 1 AS NEEDED per reaction management algorithm.
- **Hydrocortisone Sodium Succinate, 100 mg**, IV, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.
- **Famotidine, 20 mg**, IV, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.
- **Oxygen, 2 Liters/min** per nasal cannula for hypersensitivity or infusion reaction.
- **0.9% Normal Saline, 1000 mL**, IV, 150mL/hr, AS NEEDED for hypersensitivity or infusion reaction.
- **EPINEPHrine HCl (1mg/1mL), 0.3 mg**, IM injection, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.

My NPI number is ______________________________ **(MUST BE COMPLETED TO BE A VALID PRESCRIPTION)**; and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____________________________ **Date/Time:** _________________

Printed Name: __________________ **Phone:** ____________________**Fax:**________________