Spectrum Health

Patient Name
DOB
MRN
Physician
FIN

Physician's Orders
RHOGAM (RHO(D))
IMMUNE GLOBULIN (HUMAN) (IGG) - ADULT, OUTPATIENT, INFUSION CENTER

Defaults for orders not otherwise specified below:
☐ Interval: Once

Duration:
☐ Once

Anticipated Infusion Date_____ ICD 10 Code with Description_____

Height_____(cm) Weight_____(kg) Allergies_____

Provider Specialty

☐ Allergy/Immunology	☐ Infectious Disease	☐ OB/GYN	☐ Rheumatology
☐ Cardiology	☐ Internal Med/Family Practice	☐ Other	☐ Surgery
☐ Gastroenterology	☐ Nephrology	☐ Otolaryngology	☐ Urology
☐ Genetics	☐ Neurology	☐ Pulmonary	☐ Wound Care

Site of Service

☐ SH Gerber	☐ SH Lemmen Holton (GR)	☐ SH Pennock	☐ SH United Memorial
☐ SH Helen DeVos (GR)	☐ SH Ludington	☐ SH Reed City	☐ SH Zeeland

Appointment Requests

☑ Infusion Appointment Request
Status: Future, Expected: S, Expires: S+365, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Injection and possible labs

Safety Parameters and Special Instructions

☑ ONC SAFETY PARAMETERS AND SPECIAL INSTRUCTIONS 5
DO NOT ORDER THE MEDICATION WITHOUT THE LAB ORDER: Rho D immune globulin is dispensed from blood bank. The lab order for Rh Immune globulin Antenatal MUST be placed in order for the blood bank to be able to evaluate the need for the medication and dispense it.

Labs

☑ Rh Immuneglobulin Antenatal
Status: Future, URGENT, Clinic Collect

Additional Lab Orders

Labs: _____

☐ Every ___days ☐ Until date: _____
☐ Once ☐ 1 year
☐ _____# of Treatments

Medications

☑ Rho D immune globulin (HYPERRHO S/D) injection 300 mcg (1500 IU)
300 mcg (1500 IU), Intramuscular, Starting S, For 1 Dose
IM only. Administer in the deltoid muscle of upper arm or anterolateral aspect of upper thigh. Avoid gluteal region due to risk of injury to sciatic nerve. Do NOT administer IV. Full dose is 300 mcg which is equal to 1500 IU.

Telephone order/Verbal order documented and read-back completed. Practitioner's initials _____

NOTE: Unless Order is written DAW (dispense as written), medication may be supplied which is a generic equivalent by nonproprietary name.

TRANSCRIBED: TIME	DATE	VALIDATED: TIME	DATE	ORDERED: TIME	DATE	Pager #
	Sign		R.N. Sign		Physician Print	Physician

NOTE: Epic Treatment/Therapy Plan Orders. To be scanned/attached to the appropriate Infusion Referral Order in Epic.