Spectrum Health Helen DeVos children's hospital

# Physician's Orders CYTOMEGALOVIRUS IMMUNE GLOBULIN HUMAN (CYTOGAM) - PEDIATRIC, OUTPATIENT, INFUSION CENTER



Patient Name
DOB
MRN
Physician
FIN

Defaults for orders not otherwise specified below:
- ☐ Interval: Once
- ☐ Interval: Every _____ days

Duration:
- ☐ Until date: _____
- ☐ 1 year
- ☐ _____# of Treatments

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+366, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Infusion

## Provider Reminder

☑ ONC PROVIDER REMINDER 14
Pretreatment with acetaminophen and an antihistamine is recommended. For symptoms of allergic reaction or anaphylaxis, order "Peds Hypersensitivity Reactions" Therapy Plan.

## Lab Orders

| | Interval | Duration |
|---|---|---|
| ☐ _____ | ☐ Every ___days<br>☐ Once | ☐ Until date: _____<br>☐ 1 year<br>☐ _____# of Treatments |
| ☐ _____ | ☐ Every ___days<br>☐ Once | ☐ Until date: _____<br>☐ 1 year<br>☐ _____# of Treatments |

## Hydration

☑ dextrose 5% and sodium chloride 0.45% infusion

Dose:
- ☐ 50 mL/hr
- ☐ 75 mL/hr
- ☐ 100 mL/hr
- ☐ 125 mL/hr

For:
- ☐ _____ hours

Intravenous, Continuous, Starting S, For 1 Days



*CONTINUED ON PAGE 2 ➔*

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

 

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# CYTOMEGALOVIRUS IMMUNE GLOBULIN HUMAN (CYTOGAM) - PEDIATRIC, OUTPATIENT, INFUSION CENTER *(CONTINUED)*



Patient Name

DOB

MRN

Physician

FIN

## Pre-Medications – SELECT DOSE FORM

**Select Acetaminophen Tablet OR Suspension**

- ☐ acetaminophen (TYLENOL) tablet 15 mg/kg (Treatment Plan) Max Dose of 650mg
  15 mg/kg, Oral, Once, Starting S, For 1 Doses
  Administer 30 minutes prior to infusion.
  No more than 5 doses from all sources in 24 hour period, not to exceed 4000 mg/day
- ☐ acetaminophen (TYLENOL) 32 MG/ML suspension 15 mg/kg (Treatment Plan) Max Dose of 650mg
  15 mg/kg, Oral, Once, Starting S, For 1 Doses
  Administer 30 minutes prior to infusion.
  No more than 5 doses from all sources in 24 hour period, not to exceed 4000 mg/day

**Select Diphenhydramine Capsule, Injection OR Elixir**

- ☐ diphenhydrAMINE (BENADRYL) injection 1 mg/kg (Treatment Plan) Max Dose of 50mg
  1 mg/kg, Intravenous, Once, Starting S, For 1 Doses
  Administer 30 minutes prior to infusion.
  Recommended maximum single dose is 50mg
- ☐ diphenhydrAMINE (BENADRYL) capsule 1 mg/kg (Treatment Plan) Max Dose of 50mg
  1 mg/kg, Oral, Once, Starting S, For 1 Doses
  Administer 30 minutes prior to infusion.
  Recommended maximum single dose is 50mg
- ☐ diphenhydrAMINE (BENADRYL) 12.5 MG/5ML elixir 1 mg/kg (Treatment Plan) Max Dose of 50mg
  1 mg/kg, Oral, Once, Starting S, For 1 Doses
  Administer 30 minutes prior to infusion.
  Recommended maximum single dose is 50mg

☐ Pre-medication with dose: _____

☐ Pre-medication with dose: _____

## Medications

☑ cytomegalovirus immune globulin (CYTOGAM) infusion
Dose:

- ☐ 50mg/kg
- ☐ 100mg/kg
- ☐ 150mg/kg
- ☐ 200mg/kg
- ☐ 400mg/kg

Intravenous, Titrate, Starting S+30 Minutes, For 1 Doses

Infuse through a 0.2-15 micron in-line filter. Begin infusion rate at ____ mL/hr (0.3 mL/kg/hr), if tolerated, may double infusion rate every 30 minutes to a maximum rate of ___ mL/hr (1.2 mL/kg/hr)

## Nursing Orders

☑ ONC NURSING COMMUNICATION 1

- Monitor temperature, blood pressure, heart rate, respiratory rate and oxygen saturation prior to infusion and then every 15 minutes x 2, then every 30 minutes x 1, then hourly x 2, then every 2 hours for the duration of the infusion. If any signs or symptoms of an infusion related reaction occur, vital signs should be checked immediately.

- Notify provider if O2 saturation is less than or equal to 92%

- Notify provider if patient has itching, hives, swelling, fever, chills, rigors, dyspnea, or a greater than 20% decrease in systolic blood pressure from baseline.

- Verify that patient has diphenhydramine / Epi-pen available (as appropriate) for immediate home use. Advise patient that severe hypersensitivity or anaphylactic reactions may occur during and after infusion. Inform patients of signs and symptoms of anaphylaxis and hypersensitivity reactions, and importance of seeking medical care.

**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:** | | **VALIDATED:** | | **ORDERED:** | | |
|---|---|---|---|---|---|---|
| **TIME** | **DATE** | **TIME** | **DATE** | **TIME** | **DATE** | Pager # |
| | **Sign** | | **R.N. Sign** | **Physician Print** | | **Physician** |