Infusion Services – Methotrexate Ectopic Pregnancy Order Form

UNIVERSITY OF MICHIGAN HEALTH-SPARROW
MICHIGAN MEDICINE

□ Herbert-Herman Cancer Center	□ Sparrow Carson	□ Sparrow Clinton	□ Sparrow Eaton	□ Sparrow Ionia
P: 517-364-9408	P: 989-584-0052	P: 989-227-3359	P: 517-543-1050 x 52110	P: 616-523-1332
F: 517-364-8448	F: 989-584-0130	F: 989-227-3388	F: 517-541-1668	F: 616-523-1497

Legal Patient Name:	**DOB:**	**Height:**	**Weight:**	**BSA:**
ICD 10 Diagnosis Code:	**Diagnosis:**			
Allergies:				

MUST Include with Order:

- ☐ Patient Demographics & Insurance
- ☐ History & Physical & Applicable Lab/Culture Results
- ☐ Medication List
- ☐ Completed Prior Authorization (if required).
  Authorization number: _____
- ☐ Consent **REQUIRED** if ordering Blood Products and/or Chemotherapy

***UM Health-Sparrow Infusion Centers are not responsible for drawing or monitoring labs required before/after treatment.**

MEDICATION ORDERS

Name	Dose	Route	Frequency	Duration
METHOTREXATE	☐ 50mg/m2	☐ IM	☐ Once	☐ Once ☐ Other _____
	☐ _____ mcg ☐ _____ mg ☐ _____ gram ☐ _____	☐ IV ☐ IM ☐ SC ☐ PO	☐ Daily ☐ Weekly ☐ Monthly ☐ Every _____ Months ☐ PRN ☐ Other _____	☐ Once ☐ One Year ☐ Other _____

The following questions **MUST** be answered:

1. The ordering provider has personally reviewed the most recent Ultrasound findings and they are consistent with Ectopic Pregnancy. Yes _____ No _____

2. The ordering provider has examined this patient and confirmed the diagnosis is consistent with that of Ectopic Pregnancy. Yes _____ No _____

CENTRAL LINE CARE

- ☐ Use existing central line (UM Health-Sparrow Infusion Centers flush central lines with normal saline ONLY)
- ☐ Perform central line care per UM Health-Sparrow policy & procedure

To order Heparin, check below:

- ☐ FOR PORT: Heparin 500 units/ 5 ml per lumen
- ☐ FOR PICC: Heparin 250 units/ 2.5 ml per lumen
- ☐ Alteplase 2 mg IV PRN

☑ Initiate UM Health-Sparrow Infusion Emergency Protocol in the event of an allergic reaction.

Ordering Provider Name: _____ **Office Phone:** _____ **Fax:** _____

Ordering Provider Signature: _____ **Date/Time:** _____

Are you a UM Health-Sparrow credentialed provider? ☐ Yes ☐ No

Hospitalist Physician Signature (if needed): _____ **Date/Time:** _____