

KUMED
 CENTER
 3901 Rainbow Blvd.
 Kansas City, Kansas 66160
PHYSICIAN'S ORDER FORM

ADDRESSOGRAPH

MEDICATION SCHEDULE

bid 09-21 (alt 08-17) q2hours ODD or EVEN hours q12hours 09-21
 tid 09-15-21 q6hours 00-06-12-18 (alt 01-13)
 tid ac 07-11-17 (alt 09-15-21-03) qDAY 09 (alt 21)
 tid pc 09-13-19 qid 09-13-17-21 q hs 21
 tid w/meals 08-12-18 q8hours 06-14-22 (alt 09-17-01) ac hs 07-11-17-21

ROOM

All orders must be written in the metric system and must include date, time, physician's signature, and pager number.

NURSING:
 Fax to pharmacy.
 Record fax date/time.

Date & Time	C m p #	ORDERS Intravenous Immune Globulin (IVIG) Order Form- Pediatrics (Page 1 of 1)	Rph Init
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*****Pharmacy must be notified in advance to insure availability of product*****
Pediatric Pharmacist's Pager 917-7972

Allergies: _____ **Patient weight:** _____ kg

Indication: _____

Medication order (must fill in all blanks):

IVIG (**Polygam SD®**) _____ gm (400-2000mg/kg/dose) IV daily x _____ days

Begin initial infusion at _____ ml/hr (0.5 ml/kg/hr). The rate may be doubled every 30 minutes up to a max rate of _____ ml/hr (4 ml/kg/hr) as tolerated. (These rates apply to Polygam SD® product only.)

Premedication orders (optional):

Nursing Orders:

Initial dose: Vital signs (temperature, pulse, respiratory rate, blood pressure) every 15 minutes for the first hour of infusion, then every 30 minutes x 2, then every hour until infusion is complete.

Subsequent doses (if applicable): Vital signs (temperature, pulse, respiratory rate, blood pressure) every hour until infusion is complete.

If any of the following reactions are observed, decrease or interrupt the infusion and NOTIFY THE HOUSE OFFICER IMMEDIATELY: flushing, fever, nausea, diaphoresis, hypotension, urticaria, chills, dizziness, and headache.

***For more detailed information, refer to Pediatric/PICU Nursing Patient Care Protocol ***

Date: _____ Physician Signature _____ Pager _____

Intravenous Immune Globulin (IVIG) Order Form

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