

### Patient Information

Patient Name:		DOB:	
Patient Home Phone:	Patient Cell Phone:	Patient Email:	
Emergency/Alternate Contact Name:		Emergency/Alternate Contact Phone:	
NKDA	Allergies:	Weight lbs/kg:	Height:
Patient Status:	New to Therapy	Continuing Therapy	Therapy Change
Last infusion date (if applicable):			_____
Is the patient pregnant, planning a pregnancy or nursing:		Yes	No
Does the patient need interpreter services:		Yes	No

### Provider Information

Referral Coordinator Name:		Referral Coordinator Email:	
Ordering Provider:		Provider NPI:	
Referring Practice Name:		Phone:	Fax:
Practice Address:		City:	State: Zip:

### ICD-10 CODE

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### Medication Order

<b>Herceptin</b> (trastuzumab)	<b>Ontruzant</b> (trastuzumab-dttb)
<b>Dose and frequency:</b> 4mg/kg IV for initial infusion followed by 2mg/kg IV weekly	8mg/kg IV for initial infusion followed by 6mg/kg IV every 3 weeks
Other: _____	
Access/De-access PICC/port per AleraCare protocol	Do NOT administer heparin to this patient

### Documentation Required (Note: Send all labs, must include specific labs listed here)

Labs (HER2 status, pregnancy status of females of reproductive potential, cardiac assessment (LVEF))

Insurance Card (front and back)	Current Medications	History/Progress Notes
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### Pre-Medication Order

<b>acetaminophen</b> (Tylenol) 500mg 650mg 1000mg PO	<b>diphenhydramine</b> (Benadryl) 25mg 50mg / PO IV
<b>cetirizine</b> (Zyrtec) 10mg PO	<b>methylprednisolone</b> (Solu-Medrol) 40mg IV 125mg IV
<b>loratadine</b> (Claritin) 10mg PO	<b>hydrocortisone</b> (Solu-Cortef) 100mg IV
<b>ondansetron</b> (Zofran) 4mg 8mg / PO IV	
Other: _____	
Dose: _____	Route: _____
Frequency: _____	

### Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

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**Provider Name**

**Provider Signature**

**Date**

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.

Check here if this is a stat order

**Patient Information**

Patient Name:	DOB:	Sex:	M	F	Fasting:	Y	N
Patient Home Phone:	Patient Cell Phone:						
Emergency/Alternate Contact Name:	Emergency/Alternate Contact Phone:						

**Lab Test (Please circle or write in ICD-10)**

ALT	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	IgE	J45.4, J45.3, L50.9, J45.40, J45.50
AST	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	IgG	G35, G36.0
HEPATIC FUNCTION PANEL	R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	IMMUNOGLOBULIN QUANT IgG, IgM, IgA	G35, G36.0
BASIC METABOLIC PANEL	I10, E87.1, Z79.899, E87.5, E80.20, G35, M81.0, M81.8, N18.9	IMMUNOGLOBULIN QUANT IgG, IgM, IgA, IgE	G35, G36.0
CALCIUM	M81.0, M81.8	IRON, TIBC, FER PNL	D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9
CBC (INCLUDES DIFF/PLT)	I10, D64.9, Z00.00, R53.83, G35, C50.011, D70.9, D50.0, D63.1	LIPID PANEL	Z79.899, E78.5, E55.9, E78.00, Z00.00, E78.01, E78.2
CBC (H/H, RBC, WBC, PLT)s	I10, Z00.00, Z13.0, D64.9, G35, C50.011, D70.9, D50.0, D63.1	MAGNESIUM	I10, Z79.899, R25.2, E83.42, Z00.00
COMP METABOLIC PANEL	I10, Z79.899, E78.5, E11.9, E78.2, E80.20, G35, M81.0, M81.8, N18.9	PSA	R97.20, C61, N40.1, Z12.5, N40.0
CREATININE	M81.0, M81.8, G35	PROTHROMBIN TIME-INR	Z79.01, I48.91, I48.0, Z51.81
C-REACTIVE PROTEIN (CRP)	R53.83, R79.82, M35.3, I10, M06.9, K50.90, K51.90, M32.9, L40.50	TRANSFERRIN SATURATION	D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9
FERRITIN	D64.9, D50.9, D50.0, D50.8, Z00.00, D63.1, N18.9	QUANTIFERON TB GOLD	Z79.899, Z00.00, Z01.84, M06.9, M08.9, M45.0, L40.0, L40.50, K51.90, K50.90
G6PD	M1A.9XX0, M1A.9XX1	TSH	E03.9, I10, E03.8, R53.83, E06.3, E05.00
GROWTH HORMONE	E22, C7A.1, E34	URIC ACID	M10.9, E79.0, I10, Z00.00, M1A.9XX0, M1A.9XX1
HEMOGLOBIN & HEMATOCRIT	D50.9, D64.9, D50.0, D63.1, N18.9	VIT B12/FOLIC ACID	M89.49, E53.8, R53.83, F41.8, F41.9, E05.00
HEMOGLOBIN A1C	E11.9, E11.65, R73.01, Z00.00, I10	VIT D 25- HYDROX	E55.9, Z00.00, R53.83, I10, Z79.899, M81.0, M81.8
HEP B SURF AG	Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0	Miscellaneous Labs Not Listed (Write In)	

**Frequency**

Prior to each dose      Yearly      Other: Please Specify Below

Lab Test: \_\_\_\_\_ Frequency: \_\_\_\_\_

Lab Test: \_\_\_\_\_ Frequency: \_\_\_\_\_

Lab Test: \_\_\_\_\_ Frequency: \_\_\_\_\_

Lab Test: \_\_\_\_\_ Frequency: \_\_\_\_\_

Provider Name

Provider Signature

Date

Provider Phone