

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
Medication Order

Avastin (bevacizumab)

Dose and frequency:

5mg/kg (____mg) IV every 2 weeks	7.5mg/kg (____mg) IV every 3 weeks
10mg/kg (____mg) IV every 2 weeks	15mg/kg (____mg) IV every 3 weeks

Other: _____

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

Labs (urinalysis)	Insurance Card (front and back)	Current Medications	History/Progress Notes
-------------------	---------------------------------	---------------------	------------------------

Pre-Medication Order (given 30 min before each infusion)

acetaminophen (Tylenol)	500mg	650mg	1000mg PO	diphenhydrAMINE (Benadryl)	25mg	50mg /	PO	IV
cetirizine (ZyrTEC)	10mg PO			methylPREDNISolone (SOLU-Medrol)	40mg IV	125mg IV		
loratadine (Claritin)	10mg PO			hydrocortisone (Solu-CORTEF)	100mg IV			
ondansetron (Zofran)	4mg	8mg /	PO IV					

Other: _____

Dose: _____ Route: _____ Frequency: _____

Line/Port Use Orders

RN to start/discontinue peripheral IV or access/de-access port

RN to administer 3-10 mL normal saline with heparin 100 units/mL 1-5 mL per SASH method

Do NOT administer heparin to this patient

Additional orders: _____

Adverse Reaction and Anaphylaxis Orders

Standard anaphylaxis kit (EPINEPHrine 0.3 mg IM PRN for severe reactions x 1, may repeat once within 5-15 minutes for a maximum of 2 doses; Benadryl 50 mg PO PRN for mild-moderate reactions x 1; Benadryl 50 mg IV PRN for mild-moderate reactions x 1)

Additional orders: _____

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

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

Provider Signature
Date

Check here if this is a stat order