**Physician Orders ADULT**  
**Order Set: Gamma Globulin Infusion Orders**

[R] = will be ordered  
T = Today; N = Now (date and time ordered)

<table>
<thead>
<tr>
<th>Height: ___________ cm</th>
<th>Weight: __________ kg</th>
</tr>
</thead>
</table>

**Allergies:**  
[ ] No known allergies  
[ ] Medication allergy(s): ___________________________________________________________________  
[ ] Latex allergy  
[ ] Other: ____________________________________________________________________________

**Admission/Transfer/Discharge**

[ ] Admit Patient to Dr. ________________

**Admit Status:**  
[ ] Outpatient  
[ ] OP-OBSERVATION Services  
[ ] OP-Ambulatory Surgery

**Observation** - short term (usually less than 24 hrs) stay in the hospital for evaluation, treatment, assessment, and reassessment to determine need for progression to inpatient admission vs discharge to outpatient follow-up

**Bed Type:**  
[ ] Med/Surg  
[ ] Critical Care  
[ ] Stepdown  
[ ] Telemetry; Specific Unit Location: ________________

[ ] Notify Physician-Once T,N, of room number on arrival to unit

**Primary Diagnosis:** __________________________________________________________________

**Secondary Diagnosis:** __________________________________________________________________

**Vital Signs**

[ ] Vital Signs T,N, Routine Monitor and Record T,P,R,BP, q-shift

[ ] Vital Signs T,N, Routine Monitor and Record T,P,R,BP, q4h(std)

**Activity**

[ ] Out Of Bed T,N, Up As Tolerated

[ ] Ambulate T,N, With Assistance

**Food/Nutrition**

[ ] Regular Adult Diet Start at: T,N

[ ] Consistent Carbohydrate Diet T,N, Caloric Level: 1800 Calorie, Insulin: [ ] No Insulin [ ] Short Acting  
[ ] Intermediate [ ] Long Acting [ ] Short and Intermediate [ ] Short and Long; Renal Patient: [ ] No [ ] Yes, on dialysis [ ] Yes, not on dialysis

[ ] Sodium Control Diet (Low Sodium Diet) Start at: T,N, Level: 3 gm

**Patient Care**

[ ] Observe For T,N, for change in status for 30 minutes prior to each gamma globulin infusion

[ ] Weight T,N, on arrival to floor

[ ] Intermittent Needle Therapy Insert/Site (INT Insert/Site Care) T,N,q4day,for gamma globulin infusion

[ ] Nursing Communication T,N, If Serum Creatinine less than or equal to 1.2mg/dL, start IV Gamma Globulin infusion

**Respiratory Care**

**Continuous Infusions**

**Medications**

[ ] immune globulin intravenous 650 mg/kg, Injection, IV, QDay, Routine, T,N,( 3 day )

[ ] immune globulin intravenous 1,000 mg/kg, Injection, IV, once, Routine

[ ] immune globulin intravenous 500 mg/kg, Injection, IV, QDay, Routine, T,N,( 2 day )
### Physician Orders ADULT

**Order Set: Gamma Globulin Infusion Orders**

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### Medications continued

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>Other Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>diphenhydRAMINE</td>
<td>25 mg</td>
<td>Injection, IV Push</td>
<td>once</td>
<td>Routine</td>
</tr>
<tr>
<td>hydrocortisone</td>
<td>25 mg</td>
<td>Injection, IV Push</td>
<td>once</td>
<td>Routine</td>
</tr>
<tr>
<td>hydrocortisone</td>
<td>80 mg</td>
<td>Injection, IV Push</td>
<td>once</td>
<td>Routine</td>
</tr>
<tr>
<td>EPINEPPhrine 1 mg/mL Injection</td>
<td>0.3 mg</td>
<td>Injection, IM, q20min, PRN Other, specify in Comment</td>
<td>Routine, T;N</td>
<td></td>
</tr>
<tr>
<td>acetaminophen</td>
<td>650 mg</td>
<td>Tab, PO</td>
<td>PRN Fever</td>
<td>Routine</td>
</tr>
</tbody>
</table>

### Laboratory

**NOTE: the following labs should be placed on admission:**

<table>
<thead>
<tr>
<th>Test</th>
<th>Frequency</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBC</td>
<td>T;N</td>
<td>Routine, once, Blood</td>
</tr>
<tr>
<td>Comprehensive Metabolic Panel (CMP)</td>
<td>T;N</td>
<td>Routine, once, Blood</td>
</tr>
<tr>
<td>Basic Metabolic Panel (BMP)</td>
<td>Time Study</td>
<td>T;N, QDay, Blood</td>
</tr>
<tr>
<td>Urinalysis w/Reflex Microscopic Exam</td>
<td>T;N</td>
<td>Routine, once, Urine, Nurse Collect</td>
</tr>
</tbody>
</table>

### Diagnostic Tests

**Consults/Notifications**

- [ ] Consult Clinical Pharmacist Start at: T;N
- [ ] Notify Physician-Continuing T;N, shortness of breath, swelling, itching, hypotension, or severe respiratory distress

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**Date** | **Time** | **Physician's Signature** | **MD Number**
---|---|---|---

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ONC Gamma Globulin Infusion Orders

21407-QM1008 Rev062618