Physician Orders PEDIATRIC: LEB DTU Immune Globulin (Intravenous) IVIG Infusion Plan

Initiate Orders Phase
Care Sets/Protocols/PowerPlans
☐ Initiate Powerplan Phase

Phase: LEB Immune Globulin (Intravenous) IVIG Infusion Phase, When to Initiate: ____________

LEB Immune Globulin (Intravenous) IVIG Phase
Admission/Transfer/Discharge
☐ Patient Status Initial Outpatient
    T;N Attending Physician: ________________________________
    Reason for Visit: ______________________________________
    Bed Type: ______________________________ Specific Unit: DTU
    Outpatient Status/Service: [ ] Ambulatory Surgery, [ ] OP Diagnostic Procedure
    [ ] OP OBSERVATION Services

☐ Notify Physician-Once
    Notify For: of patient’s arrival to unit.

☐ Discharge Instructions
    Followup Appointments: Schedule next infusion in _____ week_____ months. (DEF)*
    Other Instructions: For IVIG Infusion.

Vital Signs
☐ Vital Signs
    Monitor and Record T,P,R,BP, q15 minutes until maximum rate reached then q1h until infusion completed.

Food/Nutrition
☐ Regular Pediatric Diet

Patient Care
☐ Height
    Routine, upon arrival to unit

☐ Weight
    upon arrival to unit

☐ INT Insert/Site Care LEB
    Routine

☐ INT Discontinue
    Discontinue after infusion is complete.

Medications
R immune globulin 10% IV
☐ ___ mg/kg, Ped Injectable, IV Piggyback, once, Routine (DEF)*
    Comments: Infuse over 2 hours-3 hours week#_. Vital signs to be performed every 15 minutes until maximum rate reached then q1h until infusion completed. Special Instructions: ok for pharmacy to round to the nearest 5 grams/whole vial

☐ 500 mg, Ped Injectable, IV Piggyback, once, Routine
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Comments: Infuse over 2 hours-3 hours week #___. Vital signs to be performed every 15 minutes until maximum rate reached then q1h until infusion completed. Special Instructions: ok for pharmacy to round to the nearest 5 grams/whole vial

☐ 1,000 mg, Ped Injectable, IV Piggyback, once, Routine
   Comments: Infuse over 2 hours-3 hours week #___. Vital signs to be performed every 15 minutes until maximum rate reached then q1h until infusion completed. Special Instructions: ok for pharmacy to round to the nearest 5 grams/whole vial

☐ 2,000 mg, Ped Injectable, IV Piggyback, once, Routine
   Comments: Infuse over 2 hours-3 hours week #___. Vital signs to be performed every 15 minutes until maximum rate reached then q1h until infusion completed. Special Instructions: ok for pharmacy to round to the nearest 5 grams/whole vial

☐ predniSONE
   ☐ 1 mg/kg, Tab, PO, N/A, Routine, To be administered prior to infusion of IVIG (DEF)*
   ☐ 30 mg, Tab, PO, N/A, Routine, To be administered prior to infusion of IVIG

☐ acetaminophen
   ☐ 325 mg, Tab, PO, once, Routine (DEF)*
     Comments: Comment: Give before infusion as premedication
   ☐ 500 mg, Tab, PO, once, Routine
     Comments: Comment: Give before infusion as premedication
   ☐ 650 mg, Tab, PO, once, Routine
     Comments: Comment: Give before infusion as premedication
   ☐ 10 mg/kg, Liq, PO, once, Routine, Max Dose: 650 mg, prior to infusion
     Comments: Comment: Give before infusion as premedication
   ☐ 15 mg/kg, Liq, PO, once, Routine, Max Dose: 650 mg, prior to infusion
     Comments: Comment: Give before infusion as premedication

☐ acetaminophen
   ☐ 325 mg, Tab, PO, q6h, PRN Pain, Mild or Fever (DEF)*
   ☐ 500 mg, Tab, PO, q6h, PRN Pain, Mild or Fever
   ☐ 600 mg, Tab, PO, q6h, PRN Pain, Mild or Fever
   ☐ 10 mg/kg, Liq, PO, q6h, PRN Pain, Mild or Fever
   ☐ 15 mg/kg, Liq, PO, q6h, PRN Pain, Mild or Fever

☐ diphenhydRAMINE
   ☐ 25 mg, Cap, PO, once, prior to infusion (DEF)*
     Comments: Comment: Give before infusion as premedication
   ☐ 50 mg, Cap, PO, once, prior to infusion
     Comments: Comment: Give before infusion as premedication
   ☐ 1 mg/kg, Elixir, PO, once, prior to infusion Max Dose 50 mg
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Comments: Give before infusion as premedication

☐ ondansetron
☐ 0.1 mg/kg, Injection, IV Push, once, Routine, Max Dose: 4mg (DEF)*
Comments: for Nausea and Vomiting
☐ 4 mg, Injection, IV, once, Routine
Comments: for Nausea and Vomiting

Laboratory
☐ CBC
☐ CMP
☐ CPK
☐ Aldolase
☐ IgA
☐ IgG Level
☐ IgM

Consults/Notifications/Referrals
☐ Notify Resident-Continuing
Notify: Allergy Immunology Fellow on call, Notify For: with any questions or concerns

Date ___________________ Time ___________________ Physician’s Signature ___________________ MD Number ___________________

*Report Legend:
DEF - This order sentence is the default for the selected order
GOAL - This component is a goal
IND - This component is an indicator
INT - This component is an intervention
IVS - This component is an IV Set
NOTE - This component is a note
Rx - This component is a prescription
SUB - This component is a sub phase, see separate sheet
R - Required order