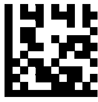
COOLEY DICKINSON HOSPITAL
MASSACHUSETTS GENERAL HOSPITAL AFFILIATE

(Patient Sticker)



PHYSICIAN ORDER SET :

MEDICAL DAY CARE Order Form
Injection and Intravenous Orders

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Patient : ____ DOB: ________________ Gender: ____________

Patient Phone : __________________________________ Height: ______________ Weight: ____________lb kg

Diagnosis : ______________________________________ ICD-10 Code: _________

Injection(s) Start Date: ____________________________

Provider Facility Name: ___________________________ Provider Facility Address: _________________________

Ordering Provider: ________________________________ Order Date: _____________________

Signature : ______________________________________

Complete, sign, and fax this document to: ***CDH Central Scheduling at 413-582-2183***.

Please include H&P/ current medications list/ allergies, and ensure that med authorizations have been obtained
For Blood Transfusions, please ensure that signed consent has been obtained.

- ☐ **Prior authorization obtained** (if needed) ___ Yes
- ☐ **Medication**: ____
- ☐ **Dose**: ____ mg _____mcg _____ mL _____ mL/kg _____ units/mL Other: ______________________
- ☐ **Route**: __________________________________
- ☐ **Length of Treatment**: ___ minute(s) ___ hour(s)
- ☐ **Frequency**:
  - ___ once
  - Every: _____ day _____ week _____ month _____ year
  - Total duration of treatments: _____ day(s) _____ week(s) _____ month(s)
  - Other: _______________________________
- ☐ Additional Info: