Comanche County Memorial Hospital

Outpatient Infusion Center
Osteoarthritis Order

Please fax form to: 580-585-5472

Patient Information

Patient Name: DOB: Phone: Gender: M F

Patient Address: Email: Insurance:

Additional Information Needed

- ☐ Fax front/back of insurance card
- ☐ Fax clinical/progress notes
- ☐ Fax labs
- ☐ Fax patient demographics
- ☐ Fax current medication list
- ☐ Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

- ☐ M17.0 Bilateral Primary OA of Knee
- ☐ M17.4 Other bilateral Secondary OA of Knee
- ☐ M17.11 Unilateral Primary OA, Right Knee
- ☐ M17.5 Other Unilateral Secondary OA of Knee
- ☐ M17.2 Bilateral Post-Traumatic OA of Knee
- ☐ M17.9 OA of Knee, Unspecified
- ☐ Other: DX: ____

Clinical Information:

- ☐ New Therapy Induction ☐ Therapy Change ☐ Therapy Continuation
- ☐ Patient Weight:____ lbs/ ____ kg ☐ Patient Height: ____ in/____cm
- ☐ Allergies:____
- ☐ Therapies Tried and Failed: ____

Lab Orders

- ☐ CBC w/o diff ☐ CMP ☐ ESR ☐ CRP ☐ HBsAg ☐ HBsAB ☐ HBcAB ☐ Quantiferon Gold
- ☐ Other: ____

Lab Orders to be done by

- ☐ Infusion Services
- ☐ Referring Provider

Prescription Information

Medication	Orders
☐ Durolane	☐ Dose: 60mg/3mL Prefilled Syringe ☐ Frequency: Intra-articularly one time ☐ Directions: ☐ Right Knee ☐ Left Knee ☐ Both Knees ☐ Other Joint: ____
☐ Gelsyn-3	☐ Dose: 16.8mg/2mL Prefilled Syringe ☐ Frequency: Intra-articularly every week for 3 weeks ☐ Directions: ☐ Right Knee ☐ Left Knee ☐ Both Knees ☐ Other Joint: ____
☐ Supartz FX	☐ Dose: 25mg/2.5mL Prefilled Syringe ☐ Frequency: Intra-articularly every week for 5 weeks ☐ Directions: ☐ Right Knee ☐ Left Knee ☐ Both Knees ☐ Other Joint: ____
☐ Other	☐ Medication:____ ☐ Dose: ____ ☐ Frequency: ____ ☐ Directions: ____

Misc Orders

- ☐ ____
- ☐ ____
- ☑ PICC/Midline/CAD dressing to be changed every 7 days

Flushes

- ☑ 10mL NS Flush Syringe PRN
- ☑ Heparin 500units/5mL Flush Syringe PRN
- ☑ 50ml NS Bag PRN
- ☑ 250ml NS Bag PRN

Standing Orders for Adverse Reaction

- ☑ Stop infusion and initiate NS bolus
- ☑ Notify Supervising physician and ordering provider
- ☑ Solu-Cortef 100mg SIVP signs of adverse reaction
- ☑ Benadryl 25 mg SIVP for hives or bronchial inflammation
- ☑ Epi 1:1000 1mL IM, IV or SQ for anaphylaxis
- ☑ Oxygen 2-5L nasal cannula
- ☑ Albuterol 2.5mg inhaled PRN to chest tightness
- ☐ Other: ____

Prescriber Information

Physician Name: ____ Official Contact Name: ____

Contact #: ____ Fax Number: ____

Address: ____ City/State/Zip: ____

NPI#:____ DEA#: ____ State License #: ____

____
Physician's Signature Date Time