Campbell County Health

An Affiliate of UCHealth

We appreciate having the opportunity to take care of your patients and give them their infusions/treatments at the Heptner Cancer Center and Infusion Clinic in Gillette, WY. The ordering provider (MD, DO, NP, DDS, DP, PA) needs to have an active Wyoming license or in the state in which they currently practice that is recognized by the state of Wyoming. The order needs to be written on an appropriate order form. We need the following information to accompany the order:

1. Provider's Full Name, Date and Time
2. Provider's NPI number, state and license number
3. Provider's Address, phone number and fax number
4. Alternate phone number of a provider on call if ordering provider is out of the office
5. Diagnosis with ICD 10 Diagnosis code
6. Patient's demographics/face sheet
7. Patient's Height, weight, allergies and DNR status
8. Infusion, Procedure, Test, or Labs being ordered
9. If patient is receiving an outpatient infusion, the most recent progress note must be included with the order.
10. Physically or electronically sign order

In order for it to be a seamless transition between you and your patient's care, we will need the above information before we can initiate a prior authorization. Our pharmacy uses biosimilar medications when available. If you prefer brand name medication, please indicate that on our order. After we obtain a prior authorization from the patient's insurance (which can take up to 7-10 business days), we will call the patient to get them scheduled. I am including some order forms for you, or you can send your own order. It is also very important for us to be able to contact you or an on-call provider in the event that your patient has a reaction or incident while they are in our care.

Please let us know if there is anything else that we can do to help you and your patients. If you have any questions or concerns please call Amie Stirling our Clinical Care Supervisor at 307-688-1922 or Matthew Miller our Director at 307-688-5025. We look forward to continuing a working relationship with you and providing care for your patients.

501 S. Burma Avenue, Gillette, WY 82716
Mailing: PO Box 3011, Gillette, WY 82717
307-688-1000

cchwyo.org

CAMPBELL COUNTY HEALTH
501 SOUTH BURMA AVENUE
GILLETTE, WYOMING 82716
P 307-688-1900
F 307-588-1920

# CANCER CENTER
# PHYSICIAN'S ORDERS

**Orders with boxes will be completed only if checked.**

An AB rated generic medication may be dispensed unless "brand medically necessary" is included in the order.

Height_____ Weight_____kg BSA:_____ Allergies:_____

**CODE STATUS:** ☐ **Full Code** ☐ **DNR** ☐ **Limited DNR / Allow Natural Death** ☐ **Palliative Care**

**DIAGNOSIS:** _____

- ☐ Xylocaine (if no allergy) 5 mg SQ PRN prior to IV or implanted port access
- ☐ Start IV or access Implanted Port/Central Line. Flush implanted port post treatment per policy
- ☐ Start maintenance fluid of Normal Saline (NS) 1000 mLs if needed to run over the treatment time. If pt has a cardiac, respiratory, or renal history infuse no more than 500 mLs
- ☐ Cathflo (Alteplace) 2 mg IVX1 PRN per policy if no blood return in port or PICC line

| **PLEASE! USE BALL POINT PEN ONLY AND DO NOT WRITE OUTSIDE MARGINS** | |
|---|---|
| Date: | Provider's Full Name: |
| Time | NPI number:<br>State and license number: |
| | Address: |
| | Phone Number:<br>Fax number:<br>On Call Provider Number |
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| | Acceptable Abbreviations for Route of Administration: PO = by mouth; NG = by nasogastric tube; IM = intramuscularly; IV – intravenously; SC = subcutaneous; Top = topically; INH = inhaled; SL = sublingual; PR = by rectum<br>***Fill out each order completely. Incomplete orders may cause a delay in therapy.*** |

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P: (307) 688-1900
F: (307)688-1920

HEPTNER CANCER CENTER/INFUSION CENTER
PHYSICIAN'S ORDERS-NON CCH CREDENTIALED ORDER SET

**Orders with boxes will be completed only if checked.**

An AB rated generic medication may be dispensed unless "brand medically necessary" is included in the order.

**Use the following to reduce errors:**

- unit
- international unit
- daily
- every other day
- morphine
- magnesium sulfate
- mL
- mcg
- write out right, left, both ears
- write out right, left, both eyes

**Height:** _____ **Weight:** _____ **kg** **Allergies:** _____

**CODE STATUS:** ☐ **Full Code** ☐ **DNR** ☐ **Limited DNR/Allow Natural Death** ☐ **Palliative Care**

**DIAGNOSIS:** _____

**CONDITION:** _____

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☐

**VITAL SIGNS:**
☐ **Routine**
☐ Other: _____

**IV THERAPY:**
☐ Flush Implanted Port per protocol
☐ TPA Implanted Port or PICC per protocol
☐ **Start IV or Access Implanted PORT/Central Line. Flush per protocol post-treatment**
☐ Other: _____

**PRE MEDICATIONS:**
☐ Benadryl _____mg IV/PO (circle one) x 1 now
☐ Zofran _____mg IV/PO (circle one) x 1 now
☐ Dexamethasone _____ mg IV/PO (circle one) x 1 now
☐ Tylenol _____mg PO x 1 now
☐ Other: _____

**MEDICATIONS TO INFUSE with specific instruction:**
☐ _____
_____
_____

**IN THE EVENT OF A REACTION:**
☐ Benadryl _____mg IVP x1 now
☐ Solu-Medrol _____mg IVP x1 now
☐ Dexamethasone _____mg IVP x1 now
☐ Zofran _____mg IVP x1 now
☐ Other: _____
☐ Other: _____

**Provider Printed Name and Phone Number:** _____
****Provider phone number must be provided to consider order complete, in the event of emergency.**

**Date ordered:** _____ **Time:** _____

**Physician Signature:** _____

Date Implemented/Revised: 02/20/2022 AR

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| Date: | |
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