Cincinnati Children's
changing the outcome together

PHYSICIAN'S ORDER FORM

Name_____

MR#_____ DOB_____

All orders must be written in the metric system and include date, time, physician's signature and pager/phone number. Use ball point pen.

Date _____ Time _____ Weight _____KG Height _____CM _____M^2

Allergies: ☐ No Drug/Contrast Allergy ☐ No Food Allergy ☐ No Product/Latex Allergy ☐ Unable to Obtain Allergy Information

Specifics:_____

Isolation Precautions: ☐ No ☐ Yes, Type_____

HOME HEALTH CARE SYNAGIS® (Palivizumab)

1. Diagnosis _____
2. Dispense Synagis® vial(s). **DO NOT SHAKE**. Deliver product to patient's home.
3. Nurse to visit for Start of Care (SOC) / Resumption of Care (ROC) / Additional therapy. SOC is when initial dose is given in the home. ROC visit within 48 hours of this order or hospital discharge, whichever comes last **– OR –** when the next dose due _____ (date). Delay in visiting is not detrimental to the patient's condition or plan of care. RN to develop/resume plan of care and visit frequency.
4. Has patient already received Synagis® dose(s) this season? ☐ No ☐ Yes
   If yes, date(s) _____ Where? _____
5. Administer Synagis® dose within 14 days before/after: _____(date). Second dose to be administered within 25-30 days after initial dose. All subsequent doses administered every 25-35 days through / no later than _____ (date).
6. **Nurse to weigh and assess patient before giving each dose.** Administer monthly intramuscular Synagis® dose as ordered below, based on the following scale. For infants greater than 15.5 KG, administer Synagis® 15 mg/KG.

MD: PLEASE DO NOT CIRCLE WEIGHT OR DOSE ON THIS ORDER
(Nurse will determine appropriate dose based on patient's weight.)

Patient Weight	Dose	Patient Weight	Dose	Patient Weight	Dose
2.00 – 2.50 KG	38 mg (0.38 mL)	6.51 – 7.00 KG	100 mg (1 mL)	11.01 – 11.50 KG	175 mg (1.75 mL)
2.51 – 3.00 KG	45 mg (0.45 mL)	7.01 – 7.50 KG	115 mg (1.15 mL)	11.51 – 12.00 KG	180 mg (1.8 mL)
3.01 – 3.50 KG	50 mg (0.5 mL)	7.51 – 8.00 KG	120 mg (1.2 mL)	12.01 – 12.50 KG	190 mg (1.9 mL)
3.51 – 4.00 KG	60 mg (0.6 mL)	8.01 – 8.50 KG	130 mg (1.3 mL)	12.51 – 13.00 KG	195 mg (1.95 mL)
4.01 – 4.50 KG	68 mg (0.68 mL)	8.51 – 9.00 KG	135 mg (1.35 mL)	13.01 – 13.50 KG	200 mg (2 mL)
4.51 – 5.00 KG	75 mg (0.75 mL)	9.01 – 9.50 KG	145 mg (1.45 mL)	13.51 – 14.00 KG	200 mg (2 mL)
5.01 – 5.50 KG	83 mg (0.83 mL)	9.51 – 10.00 KG	150 mg (1.5 mL)	14.01 – 14.50 KG	220 mg (2.2 mL)
5.51 – 6.00 KG	90 mg (0.9 mL)	10.01 – 10.50 KG	150 mg (1.5 mL)	14.51 – 15.00 KG	225 mg (2.25 mL)
6.01 – 6.50 KG	100 mg (1 mL)	10.51 – 11.00 KG	165 mg (1.65 mL)	15.01 – 15.50 KG	235 mg (2.35 mL)

If Ohio Medicaid: I had a face to face encounter on _____ (date). The clinical findings support Home Health eligibility because _____.

Physician Signature/Credentials **PRINT NAME** **Pager #** **Time** **Date**

Fax completed orders to Home Care Intake Referral: (513) 636-3951 then place orders in CCHMC medical record.

Orders faxed on: (date) _____ at (time) _____by (print name) _____

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