Premedication Order Form **FAX to 1 (888) 797-4008**

PATIENT INFORMATION		
Patient Name:		DOB:
Address:		
City:	State:	Zip code:
Patient's phone number:		
Is patient a Wayne Health patient registered in athena? ☐ Yes. ☐ No		

Order date:	Weight: kg	Height: m
Drug allergies:	☐NKDA	☐YES. Please specify.
Please specify agent/s for which pre-medication will be used:		
ICD-10 diagnosis:		

PRE-MEDICATIONS to be given before *every* infusion			
acetaminophen (Tylenol®)	☐ 500 mg PO	☐ one time	Other:
cetirizine (Zyrtec®)	☐ 10 mg PO	☐ one time	Other:
diphenhydramine (Benadryl®)	☐ 25 mg PO	☐ one time	Other:
	☐ 25 mg IV	☐ one time	Other:
famotidine (Pepcid®)	☐ 20 mg IV	☐ one time	Other:
ketorolac (Toradol®)	☐ 30 mg IV	☐ one time	Other:
	☐ 60 mg IV	☐ one time	Other:
MgSO4	☐ 1000 mg IV	☐ one time	Other:
CH3-prednisolone (Solumedrol®)	☐ 125 mg IV	☐ one time	Other:
metoclopramide (Reglan®)	☐ 10 mg IV	☐ one time	Other:
normal saline 0.9% NaCl IVF	☐ 125 mL/hr	☐ infuse 1 L	Other:
ondansterone (Zofran®)	☐ 4 mg IV	☐ one time	Other:
	☐ 8 mg IV	☐ one time	Other:
promethazine (Phenergan®)	☐ 25 mg IM	☐ one time	Other:

ORDERING PHYSICIAN INFORMATION	
Name:	NPI:
Address:	
Phone number:	Fax number:
Physician signature:	Date:

To ensure payment by insurance carrier, please include with faxed order form supporting clinical documentation for specified ICD 10 Code, demographic and insurance information. Initial appointment will be verified upon insurance approval.