



St. Charles Health System

Adult Ambulatory Infusion Order
CYANOCOBALAMIN (VITAMIN B-12)

Patient Name:
Date of Birth:

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE

Treatment Start Date: _____ **Allergies:** _____
Weight: _____ **kg** **Height:** _____ **cm**

REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety

- 1. FACE SHEET with complete INSURANCE information and patient CONTACT information**
- 2. Recent VISIT NOTE to support treatment (if not available in Epic)**
- 3. LAB RESULTS for any required prescreening (if not available in Epic)**
- 4. DIAGNOSIS CODE** _____
- 5. Patient NAME and DATE OF BIRTH on EVERY page faxed**

NURSING ORDERS:

1. Vital Signs: Initial, PRN

MEDICATIONS:

1. Select number of doses:
Administer cyanocobalamin (vitamin B-12) injection 1000 mcg subcutaneously every 28 days for (____) doses

INFUSION MONITORING/REACTION:

Infusion Reaction. Acute Infusion and Hypersensitivity Medication Protocol will be used unless the provider selects the option below. If opting out, alternative orders must be included.

1. diphenhydramine 25 mg IV, AS NEEDED x1 for hypersensitivity reaction
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. methylprednisolone 125 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. sodium chloride 0.9% 1000 mL IV, 200 mL/hr, AS NEEDED x 1 dose for alteration in hemodynamic status
6. albuterol 2.5 mg/3 mL nebuler, AS NEEDED x1 dose for hypersensitivity reaction

Opting out of standard protocol. Alternative orders are attached, or deviations are documented:

Patient will be treated at the following infusion location:

- St. Charles Outpatient Infusion Center
2500 NE Neff Road, Bend, OR 97701
Phone: (541) 706-5820 Fax: (541) 706-5825



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By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION

Signature: _____ License #: _____ Date: _____

Print Name: _____ Phone: _____ Fax: _____

Plan will expire 1 year after signature date at which time a new order will need to be placed