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| ADULT AMBULATORY INFUSION ORDER  **Methotrexate** | **NAME:**  **BIRTHDATE:**    *Affix Patient Identification Label Here* |
| **ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (**  **) TO BE ACTIVE.** | |

**Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_**

\***Please fax a copy of the** □Demographics □ Insurance Information □ Current Lab Results

**following patient information**: □ H & P Relevant to Diagnosis □ Last infusion note □ Current Medications

Provider Information

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Provider’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Information

Weight: \_\_\_\_\_\_\_\_\_\_\_\_ lbs/kg Height: \_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BSA: \_\_\_\_\_\_\_\_\_\_\_\_\_ NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_\_ Fax: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_\_

ICD-10: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Methotrexate:**

* **50 mg/m2=\_\_\_\_\_\_\_ mg, intramuscular, ONCE.**

**Final concentration is 25 mg/mL. Total dose may be divided into two syringes.**