Palmetto Infusion Services

MRN:_____

Phone: 800-809-1265 **DOB:** _____

STANDARD ALBUMIN PLAN OF TREATMENT

(Re)Certification Period from _____ to _____

Note: We may require MD office notes and/or a letter of Medical Necessity (depending on diagnosis), to be able to verify eligibility and payment for this treatment through patients Medicare and/or other insurance plan.

Patient's Name _____ HT: _____ WT: _____ Allergies: _____

Diagnosis: ☐ Primary: _____
☐ Secondary: _____

Premedication: ☐ None ***or*** ☐ 30 minutes prior to infusion with 650 mg Acetaminophen PO ***and*** one of the following *oral* antihistamines:

☐ Diphenhydramine 50 mg ☐ Fexofenadine 60 mg ☐ Fexofenadine 180 mg ☐ Cetirizine 10 mg ☐ Loratadine 10 mg

Orders:

Obtain weight each visit. Vital Signs: baseline then every 30 minutes until infusion complete and 1 hour post.
Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. Assess patient response to therapy. Pump, tubing, and supplies needed to complete prescribed therapy. Utilize existing central line for administration, or initiate a peripheral IV with each infusion, prn.
Normal Saline Flush 5-10 ml pre- infusion, after primary drug has infused, infuse Normal Saline 0.9% 20-50 ml to flush tubing/line followed by Heparin Lock 1-5ml 100 units/ml as needed per line type.
If adverse drug reaction, Implement the Standing Adverse Reaction protocol.

Dose:

☐ Albumin _____ gm of _____% in _____ ml ☐ NS *or* ☐ D5W

Infuse at _____ ml/minute
Monitor patient for 1 hour post infusion

Frequency:

☐ Orders to be completed _____

Other:

Pharmacist to perform clinical drug monitoring

(no stamped signatures please)

Physician's Signature: _____ _____ Date: _____
(Dispense as written) (Substitution permitted)

Print Physician Name: _____

PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION TO ***866-872-8920***