HARTFORD HOSPITAL
80 Seymour St. P.O. Box 5037
Hartford, CT 06102-5037

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Check box to initiate order

**Hemo/Oncology Physician Order**

**ALLERGIC:** ☐ NO ☐ YES _____

| DATE/TIME MD SIGNATURE | PHYSICIAN'S ORDERS (excludes medication orders) | NOTED BY WHOM | DATE/TIME MD SIGNATURE | MEDICATION ORDERS (includes iv's blood components) | NOTED BY WHOM |
|---|---|---|---|---|---|
| | Diagnosis _____ | | | ❑ Transfuse _____ Units | |
| | | | | pRBC's | |
| | | | | Pre-med: Tylenol 650mg P.O. X1 | |
| | | | | Benadryl 25mg P.O. X1 | |
| | | | | ❑ Transfuse 5 units platelets | |
| | | | | Pre-med: Tylenol 650mg P.O. X1 | |
| | | | | Benadryl 25mg P.O. X1 | |
| | Labs | | | ❑ Other | |
| | | | | ❑ Lasix 20mg P.O/IV | |
| | | | | ❑ Procrit 40,000 units SC | |
| | | | | ❑ Neulasta 6mg SC | |
| | | | | ❑ Neupogen 480mg SC x _____ days | |

HH Forms 546820 N03/10

PHYSICIAN'S ORDER FORM

6804