NORMAN REGIONAL Health System

Outpatient Infusion Center

Fax: 405-515-5089
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ORD

Methotrexate, Ectopic Pregnancy

Patient and Physician Information

Patient Name:	Date of Birth:	Patient Phone Number:
Physician Name:	**Office Phone Number:**	**Fax Number:**
Insurance:	**Group Number:**	**Policy Number:**
Hospitalization Status:	**Patient Weight (kg):**	**Height (inches):**
☑ Outpatient to Outpatient Infusion Center		
Allergies:		

*****Send patient demographics/insurance, clinical notes, and test results with orders*****

Diagnosis Code/Description for treatment:

☑ Ectopic Pregnancy

Laboratory

☑ CBC WITH DIFFERENTIAL
☑ COMPREHENSIVE METABOLIC PANEL
☑ TYPE AND SCREEN if indicated to be RH negative
☑ HCG, QUANTITATIVE
☑ PROGESTERONE
☑ RHIMMUNE GLOBULIN (Rhogam) prior to discharge, if indicated.

Diagnostic Tests

☑ US ABDOMEN COMPLETE

Orders

☑ Methotrexate 50 milligram/meter squared INTRAMUSCULAR ONCE x 1 dose (Dose: ____ MG = 50 x ____ BSA) – If total volume of the dose is GREATER THAN 2 milliliters, split the dose equally between 2 syringes (NOT to EXCEED 2 mL/syringe). Administer in EACH hip, MUST be administered by a nurse trained in administration and disposal of Methotrexate.
NOTE: DOSE is PER METER SQUARED, BASED on BODY SURFACE AREA (BSA)

Infusion Reaction

☑ If infusion reaction occurs, stop the infusion IMMEDIATELY, notify physician with details of reaction AND initiate the Outpatient Infusion HYPERsensitivity, OIC orders #1024

Discharge

☑ Discharge home 30 minutes after treatment complete if stable.

☑ Instruct patient to AVOID intake of Folic Acid including prenatal vitamins until advised by physician.
☐ Schedule follow-up labs – CBC, Quantitative HCG, CMP in 4 days
☐ Schedule follow-up labs – CBC, Quantitative HCG, CMP in 7 days

Date and Physician Signature

DATE:_____ **TIME:**_____

_____
PHYSICIAN'S SIGNATURE

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DO NOT WRITE ON OR BELOW THIS AREA ORDERS MAY BE CUT OFF BY FAX MACHINES