Infusion
Thyrogen Clinic Order

Salem Health® Hospitals & Clinics

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **MI:** _____

Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

PHYSICIAN ADMISSION DATA

Referring MD: _____ Date of Referral: _____

Phone Number: _____ Fax Number: _____

Primary Care Physician: _____ Phone Number: _____

Primary Diagnosis and ICD-10 code and description

Primary diagnosis: (ICD-10)_____(Description)_____

Patient Weight: _____ Patient Height:_____

Allergies:_____

Is the patient ambulatory? ☐ Yes ☐ No Does the patient require bariatric equipment? ☐ Yes ☐ No

Does the patient have a nuclear imaging scan scheduled 24 hours after second and final injection? ☐ Yes ☐ No

Location _____ Date/time: _____

PATIENT MUST BE SCHEDULED FOR IMAGING 72 HOURS FOLLOWING SECOND INJECTION.

ORDER INSTRUCTIONS

1. Thyrotropin (Thyrogen) 0.9mg IM x 2 consecutive days

Injection 1: Date: _____Injection 2: Date: _____

Confirm date of nuclear imaging scan:_____

Provider Signature _____ Provider printed name _____ Date: _____