PLACE LABEL HERE

Name: _____

Unit #: _____

Account #: _____

Premier Health
Methotrexate for Ectopic Pregnancy Order Form
(10-19)

Check All Boxes That Apply and Mark Out, Date and Initial Any Auto Checked Boxes That Do Not Apply:

Patient Name: _____ **DOB:** _____

Height: _____ (Measured Height) **Current Weight (kg):** _____ **BSA (m^{2}):** _____

Diagnosis: ☑ Ectopic Pregnancy ☐ Other: _____

Insurance: _____

*Please attach a copy of the patient's insurance information to this order.

Prior to administration of Methotrexate, the following MUST^ be documented in the medical record and a hard copy must accompany order:

1. Baseline Lab Results: CBC, CMP, HCG Quantitative, Blood Type

2. Ultrasound results (performed prior to administration of Methotrexate) Date Ultrasound Performed: _____

^If these criteria are not met, Methotrexate MUST be administered by an OB Provider.

Medication Orders:

☑ Methotrexate 50mg/m^{2} = _____mg IM x 1 dose

Additional Orders: _____

_____

Attestation by OB provider:

As the OB care provider, I have reviewed the clinical and laboratory data including the ultrasound results. It is my clinical judgement that this is an ectopic pregnancy and that the fetus or embryo has stopped developing and the tissue is dead. (your signature below serves as both your attestation to the above statement and your authorization of the above orders)

PHYSICIAN SIGNATURE: _____ **ID #:** _____ **DATE/TIME:** _____

Orders complete by RN: _____ DATE/TIME: _____