Holland Hospital

**AMBULATORY TREATMENT UNIT**

# Intramuscular (IM) Injection Order Set

☐ = Optional Order ● = Routine Order (Cross out and initial **BULLETED ORDERS** that do not apply)

Phone (616) 394-3547
Fax (616) 394-2139

**ORDERS**

**Date:** _____ **Time:** _____ **Diagnosis Code: (ICD-10)** _____

**Patient Name**: _____ **Date of Birth:** _____ **Weight:** _____ (kg)

**Allergies**: _____

**MEDICATION**

Medication _____ Dose _____

Frequency _____ Duration _____

Date of first outpatient injection to be given _____

**Please send completed for to ATU Scheduler**

Provider Signature: _____ Date: _____

Provider Name and Credentials (please print): _____ Time: _____

Office Phone: _____ Office Fax: _____