THE UNIVERSITY OF KANSAS HOSPITAL 3901 Rainbow Boulevard Kansas City, Kansas 66160 **PHYSICIAN'S ORDER FORM**	**Do not write in this box** DT0017	**PATIENT LABEL**

DATE & TIME	#	ORDERS **THYROTROPIN ALFA (THYROGEN®) INJECTIONS**
		Reference: www.thyrogen.com accessed 3/25/2009.
	1.	Attending Physician:_____ Pager:_____ Resident Physician:_____ Pager:_____
	2.	**Diagnosis:** **ICD-9 Code:** ☐ **193 (Malignant neoplasm of thyroid gland)**
	3.	**Allergies:** **Patient weight:** _____**kg**
	4.	**Labs** to be drawn prior to infusion:
	5.	**Nursing:** • Obtain patient's VS prior injection
	6.	**Medications:** Thyrotropin alfa 0.90 mg IM qd x _____days (Injections to be given consecutive days-24 hours apart, the last injection 24 hours prior to radiation dosing)
	7.	Discharge to home.

Physician Signature: _____ Pager: _____