

ADMIT to outpatient infusion service **Methotrexate Injection for Ectopic Pregnancy**

Please fax Order, Demographic sheet and Ultrasound report to 334.528.1510 **during** infusion hours.

Please fax Order, Demographic sheet and Ultrasound report to 334.528.2346 **after** infusion hours.

**Diagnosis:**

☐ TUBAL ECTOPIC PREGNANCY

**Lab:**

**\*Labs must be done prior to scheduling injection**

Labs needed: CBC with Diff, Profile 1, and Quantitative Serum hCG

\* Hold and notify Physician if hCG  $\geq$  5000 million IU/ml

**\*Labs must be resulted prior to 2pm on Monday through Thursday and before 10am on Friday for treatment in the Infusion Center. Otherwise, send patient to Emergency Department.**

**Imaging:**

**\*Ultrasound must be done prior to scheduling injection.** Please forward copy of Ultrasound report with order.

**Infusion Orders**

Drug	Fluid	Total dose	Route
Methotrexate Injection	N/A	50mg/m <sup>2</sup>	IM

**Ancillary Treatment/Administrative Procedures**

- ❖ May use Infusion Center Non-Oncology Standing Orders.
- ❖ Total dose may be divided into two syringes.
- ❖ Call ordering Physician's office and notify of the next injection date scheduled.

\_\_\_\_\_  
Ordering Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

**EAST ALABAMA MEDICAL CENTER**  
**Methotrexate Injection for Ectopic Pregnancy**  
**Order Set**

**Patient Identification**