

**Order Set Request Form**

*(To Be TYPED and Completed by the Requestor)*

*Incomplete application will not be considered (or) will be postponed for discussion*

If you have any questions, please feel free to contact Dr. Atkin’s Office (973-972-0442).

**Date of the request:**

***Requesting physician or Staff (Print)*** ***Signature Date***

***Office phone or pager E-mail address Specialty Division/Title***

**REGUIRED *Chief of Service or Division/service designee (print) Signature Specialty Date***

**ORDER SET REQUEST DESCRIPTION / INFORMATION:**

**NEW ORDER Set** (Attach typed, written or formatted order set)

1. **Requesting SERVICE**:

1. **Rationale for the new order set** (select all that applies)

High Volume

High risk patient

High risk drug

Meaningful Use Requirement

Standardized Protocol

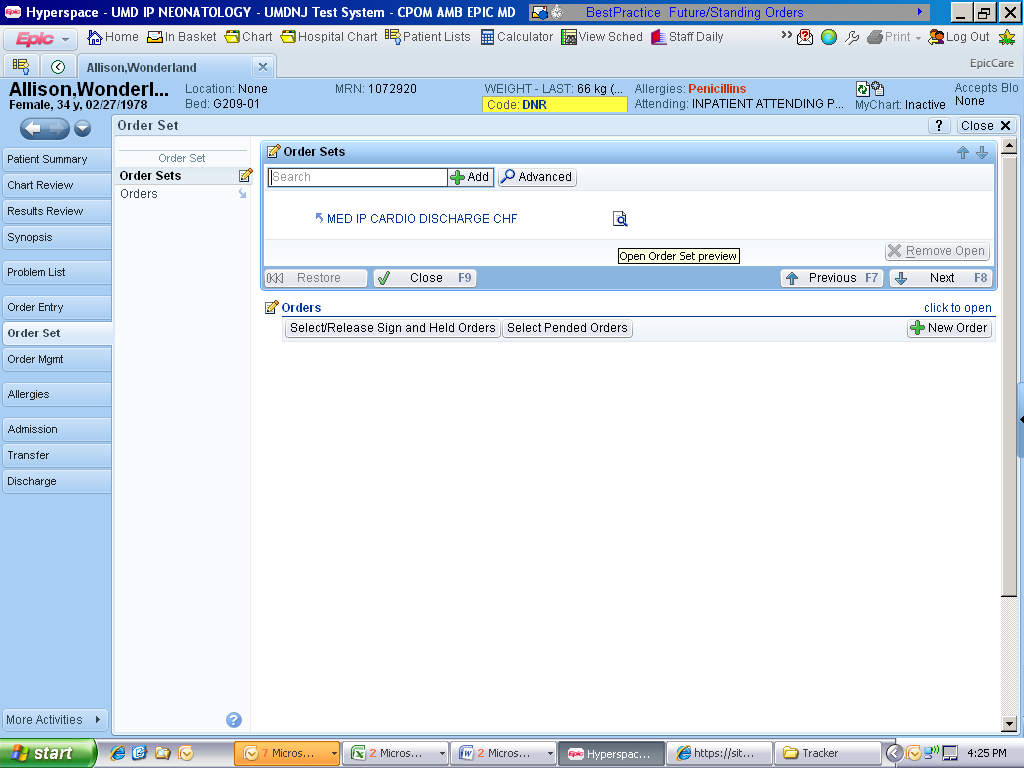
Other:

1. **Anticipated use annually**

**In-Pt:**  < 100 100- 500 501 - 1000 > 1000

**Out-Pt:** < 100 100- 500 501 - 1000 > 1000

     **MODIFY/CHANGE existing Order Set** (Attach a printed copy of existing order set with changes marked)

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To print existing order set

**Order set#** \_\_\_\_\_\_\_\_\_\_  **Order Set Committee USE ONLY**  **Priority:**

Ancillary Procedure Review Sent: \_\_\_\_\_\_\_\_\_\_\_\_\_ Procedure review complete date: \_\_\_\_\_\_\_\_ **□**patient safety (24h)

Nursing Review Sent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nursing Review Complete: \_\_\_\_\_\_\_\_\_\_\_ □High (1-3 days)

Medication completion date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Validation Session required: **yes/no** □Medium (7 days)

Final Validation Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Migrated to Production: \_\_\_\_\_\_\_\_\_\_\_\_\_ **□**Low (2-3 weeks)

□Request denied