Edward-Elmhurst Cancer Centers
120 Spalding Drive; Suite 111; Naperville, IL 60540
Phone: 630/646-2273 Fax: 630/548-6617

24600 W. 127th Street; Plainfield, IL 60585
Phone: 630/646-2273 Fax: 630/548-6617

177 E. Brush Hill Road; Elmhurst, IL 60126
Phone: 630/646-2273 Fax: 331/221-3887

Methotrexate Injection Worksheet For Ectopic Pregnancy

Patient Name: _____ Date of Birth: _____

*****Please include current history and physical and any recent labs/tests*****

Diagnosis (ICD-10 Required): _____

Height: _____ Weight (lbs/kg): _____ = BSA: _____ m2

Patient required to wait for lab results before proceeding (please check one) ☐ Yes ☐ No

☐ Patient has been educated about diagnosis, drug, lab and follow up care.

☐ Office note demonstrating ectopic pregnancy received.

☐ Ultrasound report given.

(Note: BSA/dose will be calculated and confirmed at time of injection by the staff at the Cancer Center. If you wish to be called with the calculated dose before the injection, please indicate below).

Dose: 50mg/m2 = _____ (give IM x 1)

Pre-Injection Requirements:

☐ WBC

☐ Liver Profile

☐ Creatinine

Required from MD Office

☐ ABO Rh

☐ BHCG (latest)

☐ BHCG (prior)

Please note the following contraindications:

- **Evidence of ectopic rupture**
- **Gestational sac greater than 4cm if no cardiac activity**
- **Gestational sac greater than 3.5cm if cardiac activity is present**
- **BHCG level greater than 5000 mIU/ml**
- **WBC less than or equal to 1500/mm3**
- **Creatinine greater than 1.5mg/dL**
- **AST greater than 2 times upper limits of normal**
- **Patient unreliable or unable to follow up for appointments**

Please note that the Cancer Center requires evidence of ectopic pregnancy prior to administration of any methotrexate injection. However, we are unable to interpret results and may need to call to clarify orders. Patients are instructed to follow up with their referring physician for their labs and any further care.

In the event that your patient has a central line, it will be used per the Cancer Center protocol, unless otherwise directed.

Physician Signature: _____ **Date:** _____

Ordering Physician NPI: _____

Edward Hospital NPI: **1427069632**

Elmhurst Hospital NPI: **1548306343**

Physician Name (Please Print) **Office Phone** **Fax Number**

Revision/Review Date: 07/01/2021