UPMC
LIFECHANGINGMEDICINE

Subject Name:_____

Subject MRN: _____

Subject ID:_____

Date/Time **Due**:_____

Deliver to:_____

please circle one: **initial** order
subsequent order dose form change

PHYSICIAN'S ORDER SHEET
PRO15050414 (AWAKE)

UTHORIZATION IS GIVEN TO PHARMACY TO DISPENSE AND TO THE NURSE TO ADMINISTER THE GENERIC OR CHEMICAL EQUIVALENT WHEN THE DRUG IS FILLED BY THE PHARMACY OF PRESBYTERIAN UNIV HOSPITAL OR MONTEFIORE UNIV HOSPITAL - UNLESS NAME IS CIRCLED

DATE	TIME	***IDS*** PRO15050414
		TITLE: Amantadine to Stimulate Wakefulness Following Post-Anoxic Encephalopathy (AWAKE) **IRB#: PRO15050414** **PRINCIPAL INVESTIGATOR: Jon Rittenberger, MD** **CO-INVESTIGATORS: Clifton Callaway, MD; Cameron Dezfulian, MD; Ankur Doshi, MD; Jonathan Elmer, MD; Lillian Emlet, MD, Philip Empey, Pharm D; Frank Guyette, MD; Bradley Molyneaux, MD** **COORDINATOR: Sara DiFiore Phone: 412-864-2284** **FAX ORDER TO (412)647-9651 M-F 6:30A-3P and call 864-3270 to confirm receipt of fax** **After hours, FAX to main pharmacy @ (412)647-7222 and call 412-647-1035 to confirm** **PATIENT CONSENT SIGNED: YES or NO** (circle one) **STRATUM:** **PCAC II with malignant EEG** **PCAC II without malignant EEG** ***(circle one)*** **PCAC III** **PCAC IV** **4-digit RANDOMIZATION NUMBER: _____ _____ _____ _____** **DISPENSE: Amantadine 100mg/Placebo** **DOSE FORM TO DISPENSE:** *(circle one)* **100mg/10ml oral liquid** *OR* **100mg oral capsule** **DIRECTIONS: Take 100mg twice daily at 6AM and NOON for 7 days.** **PHYSICIAN SIGNATURE:_____DATE:_____**

INVESTIGATIONAL DRUG SERVICE
PATIENT ENROLLMENT SHEET

Study Title: Amantadine to Stimulate Wakefulness Following Post-Anoxic Encephalopathy (AWAKE)

IRB#: PRO15050414

PI: Jon Rittenberger, MD

Patient Name:_____ ____ _____
first mi last

Patient Address:_____
_____
_____

Patient Phone number: (_____) _____

Social Security Number: _____

Date of birth:_____

Allergies:_____

Patient signed informed consent on file: YES / NO(circle one)

Scheduled first day of therapy:_____

Enrollment completed by:_____

Phone number for questions:_____

Fax completed form to the IDS Office at 647-9651
Please call to IDS Office with any questions at 647-4958 or 647-3178 (pharmacists) or 647-9065 (technician)

		DOSE MODIFICATION	
Date	DRUG	MODIFICATION	REASON
1)_____	_____	_____	_____
2)_____	_____	_____	_____