NEW ENGLAND
Cancer Specialists
Infusion Center
Kennebunk · Portsmouth · Scarborough · Topsham
Phone: 207-303-3225 Fax:207-692-2473

Desmopressin (DDAVP) Order Form- J2597

Patient Name:_____ **DOB:**_____

Diagnosis: _____ Diagnosis Code:_____

Height: _____(cm) Actual Weight: ____(kg) Allergies: _____

Desmopressin IV dosing:

☐ **0.3 mcg/kg IV x 1 dose. Dose equal to _____ mcg**

maximum dose: 20 mcg/dose for von Willebrand disease and 20-30 mcg/dose for hemophilia A

Orders valid through ____/_____/___

In the event of a hypersensitivity reaction, patients will be treated according to NECS protocols for the management of infusion-room drug reactions.

Provider Name: _____

Provider Signature: _____ Date: _____

Phone: _____ Fax: _____ Pager: _____