



**PLEASE ATTACH PATIENT DEMOGRAPHIC AND INSURANCE INFORMATION**

PATIENT DEMOGRAPHICS			
<b>PATIENT NAME</b>	<b>DOB</b>	<b>HEIGHT</b>	<b>in</b> <b>WEIGHT</b> <b>kg</b>
<b>DIAGNOSIS</b>	<b>PHONE #</b>	<b>ALLERGIES</b> Include OTC/herbal	
<b>PRIMARY INSURANCE</b>		<b>PRIMARY INSURANCE #</b>	
<b>EMERGENCY CONTACT</b>		<b>PHONE #</b>	

THERAPY INFORMATION			
<b>ORDERING PROVIDER</b>		<b>PHONE #</b>	
<b>FOLLOWING PROVIDER</b>		<b>PHONE #</b>	
<b>TYPE OF IV ACCESS</b>	<input type="checkbox"/> <b>Central Line</b> (Tunneled/Non-tunneled) <input type="checkbox"/> <b>Peripheral IV</b> <input type="checkbox"/> <b>Port:</b> Needle size _____ Accessed _____ <input type="checkbox"/> <b>Midline:</b> _____ lumen <input type="checkbox"/> <b>PICC:</b> _____ lumen <input type="checkbox"/> <b>Other:</b>		

PROVIDER ORDERS*										
MEDICATION	DRUG	DOSE	ROUTE	FREQUENCY	THERAPY LENGTH	QUANTITY	START DATE	STOP DATE		
	<input type="checkbox"/> Cubicin®	6 mg/kg	IV	q 24 hours		#QS				
	<input type="checkbox"/> Invanz®	1 gram	IV	q 24 hours		#QS				
	<input type="checkbox"/> Vancomycin	1000 mg	IV	q 12 hours		#QS				
	<input type="checkbox"/> Ceftriaxone	2 grams	IV	q 24 hours		#QS				
	<input type="checkbox"/>		IV	q _____		#QS				
FLUSH PROTOCOL (Select one)	<input type="checkbox"/> <b>Peripheral IV (PIV)</b> Flush with 0.9% NaCl (5 mLs) before and after medication, followed by heparin lock (10 units/mL) 5 mLs as a final lock (SASH) # QS									
	<input type="checkbox"/> <b>Midline, PICC, Central Venous Catheters</b> (Single, double, triple lumen) Flush with 0.9% NaCl (10 mLs) before and after medication, followed by heparin lock (10 units/mL) 5 mLs after completion of medications (SASH); Flush additional lumen with 0.9% NaCl (10 mLs) followed by heparin lock (10 units/mL) 5 mLs once daily #QS									
	<input type="checkbox"/> <b>Port</b> Flush port with 0.9% NaCl (10 mLs) before and after medications, followed by heparin lock (100 units/mL) 5 mLs after completions of medications #QS									
	<input type="checkbox"/> <b>Other:</b>									
SUPPLIES	<input type="checkbox"/> <b>Supplies and pumps</b> necessary to maintain and administer medication									
ANAPHYLAXIS KIT	<input type="checkbox"/> <b>Anaphylaxis Kit:</b> Diphenhydramine 50 mg (1 vial); Epinephrine 1:1000 (2 vials); Supplies for administration <ul style="list-style-type: none"> <li>• <b>Allergic response</b> - As per provider order: Diphenhydramine 50 mg slow IV push over 2-3 minutes</li> <li>• <b>Anaphylaxis</b> - As per provider order: Diphenhydramine 50 mg slow IV push over 2-3 minutes <b>OR</b> deep IM injection; Epinephrine 1:1000 solution: 0.4 mg (0.4 mL) subcutaneous injection; If needed, may repeat in 20 minutes times 1 dose</li> </ul>									
IV ACCESS MAINTENANCE	<input type="checkbox"/> <b>IV therapy administration</b> by skilled nursing personnel <input type="checkbox"/> <b>Patient education</b> on administration of IV therapy performed during skilled nursing visit <input type="checkbox"/> <b>Peripheral IV site</b> to remain on condition site viable; Restart upon any level of pain/tenderness, changes in skin color or temperature, edema, induration, fluid leakage/drainage, or other abnormality and as needed to maintain therapy access <input type="checkbox"/> <b>Subcutaneous port re-access</b> every 7 days and as needed at home or clinic <input type="checkbox"/> <b>Dressing change</b> every 7 days and as needed; change immediately if damp, loosened, or visible soiled									
LABS	Perform weekly lab draw on Mondays, as follows:	Lab draw per: (Select one) <input type="checkbox"/> Home Health <input type="checkbox"/> Clinic	Lab orders: (Select all that apply)							
			<input type="checkbox"/> CBC <input type="checkbox"/> BMP <input type="checkbox"/> BUN <input type="checkbox"/> CPK <input type="checkbox"/> CRP <input type="checkbox"/> ESR <input type="checkbox"/> CBC w/diff <input type="checkbox"/> CMP <input type="checkbox"/> Creatinine <input type="checkbox"/> Other: _____ <input type="checkbox"/> _____ trough, via peripheral venipuncture, prior to _____ dose then weekly							
<b>Fax lab results to:</b> <input type="checkbox"/> Vital Care of Meridian <input type="checkbox"/> Providers office										

\*Product selection permitted unless dispense as written checked or clearly written on order

**DISPENSE AS WRITTEN**

<b>PROVIDER SIGNATURE</b>	<b>DATE/TIME</b>
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