

ANTIBIOTIC INFUSION THERAPY ORDER FORM

Phone: 601.482.4003 Fax 601.482.3948

PLEASE ATTACH PATIENT DEMOGRAPHIC AND INSURANCE INFORMATION

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

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

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"/> Peripheral IV (PIV) 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"/> Midline, PICC, Central Venous Catheters (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"/> Port 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"/> Other:								
SUPPLIES	<input type="checkbox"/> Supplies and pumps necessary to maintain and administer medication								
ANAPHYLAXIS KIT	<input type="checkbox"/> Anaphylaxis Kit: Diphenhydramine 50 mg (1 vial); Epinephrine 1:1000 (2 vials); Supplies for administration <ul style="list-style-type: none"> • Allergic response - As per provider order: Diphenhydramine 50 mg slow IV push over 2-3 minutes • Anaphylaxis - As per provider order: Diphenhydramine 50 mg slow IV push over 2-3 minutes OR 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 								
IV ACCESS MAINTENANCE	<input type="checkbox"/> IV therapy administration by skilled nursing personnel <input type="checkbox"/> Patient education on administration of IV therapy performed during skilled nursing visit <input type="checkbox"/> Peripheral IV site 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"/> Subcutaneous port re-access every 7 days and as needed at home or clinic <input type="checkbox"/> Dressing change 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						Fax lab results to: <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

PROVIDER SIGNATURE	DATE/TIME
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