NORMAN REGIONAL Health System

Outpatient Infusion Center

Fax: 405-307-2244
Phone: 405-515-2470

ORD

Intravenous Infusion

Patient and Physician Information

Patient Name:	Date of Birth:	Patient Phone Number:
Physician Name:	**Office Phone Number:**	**Fax Number:**
Insurance:	**Group Number:**	**Policy Number:**
Hospitalization Status:	**Patient Weight (kg):**	**Height (inches):**
☑ Outpatient to Outpatient Infusion Center		
Allergies:		

*****Send patient demographics/insurance, clinical notes, and test results with orders*****

Diagnosis Code/Description for treatment: _____

Orders

Initiate IV Vascular Access Flush Orders #0643 for: ☐ Peripheral Line ☐ Midline ☐ PICC ☐ Port

☑ Normal Saline 0.9% Solution 20 milliliter/hour INTRAVENOUS (J7050 : 250 ML = 1 unit)
☐ Ceftaroline (Teflaro) _____ GM INTRAVENOUS TWICE DAILY x ___ days (J0712 : 10 MG = 1 unit)
☐ CefTAZIDime (Fortaz) _____ GM INTRAVENOUS EVERY ___ HOURS x ___ days (J0713 : 500 MG = 1 unit)
☐ CefTRIaxONE (Rocephin) _____ GM INTRAVENOUS EVERY 24 HOURS x ___ days (J0696 : 250 MG = 1 unit)
☐ Daptomycin (Cubicin) – DOSE _____ milligram/kilogram [TOTAL DOSE _____ MG] INTRAVENOUS EVERY 24 HOURS - round up to nearest 5 MG. (J0878 : 1 MG = 1 unit)
☐ Ertapenem (Invanz) _____ GM INTRAVENOUS EVERY 24 HOURS x __ days (J1335 : 500 MG = 1 unit)
☐ Oritavancin (Orbactiv) 1200 MG INTRAVENOUS ONCE (J2407 : 10 MG = 1 unit)
☐ Dalvance 1500 MG INTRAVENOUS ONCE if creatinine clearance 30 mL/min or GREATER or End-Stage Renal Disease patient on routine hemodialysis (J0875 : 5 MG = 1 unit)
☐ Dalvance 1125 MG INTRAVENOUS ONCE if renal insufficiency with creatinine clearance LESS THAN 30 mL/min UNLESS End-Stage Renal Disease patient on routine hemodialysis (J0875 : 5 MG = 1 unit)
☐ Piperacillin/Tazobactam (Zosyn) _____ GM INTRAVENOUS EVERY ___HOURS x __ days (J2543 : 1.125 GM = 1 unit)
☐ VancoMYCIN _____ GM INTRAVENOUS EVERY ____ HOURS x __ days (J3370 : 500 MG = 1 unit)
☐ VANCOMYCIN,TROUGH every ___ days, prior to infusion. (80202)
**Fax MOST recent creatinine/metabolic panel results.

Other: _____

Infusion Reaction

☑ If infusion reaction occurs, stop the infusion IMMEDIATELY, notify physician with details of reaction AND initiate the Outpatient Infusion HYPERsensitivity, OIC orders #1024

Discharge

☑ Discharge home 30 minutes after treatment complete if stable.

Date and Physician Signature

DATE:_____ **TIME:**_____

_____
PHYSICIAN'S SIGNATURE

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DO NOT WRITE ON OR BELOW THIS AREA ORDERS MAY BE CUT OFF BY FAX MACHINES