



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)
- ☐ Ceftriaxone (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: _____
07962512

TIME: _____

PHYSICIAN'S SIGNATURE