Infusion Solutions Inc.
Home Infusion & Specialty Pharmacy

477 W Horton Rd
Bellingham, WA 98226
Phone (360) 933-4892
Fax (360) 933-1197

Patient Name: _____

Date of Birth: _____ Wt: _____ Ht: _____

IV Access: _____

Allergies: _____

IV Antibiotic Order Form

- **Orders are initiated unless crossed out by provider.**
- ☐ **Check box to initiate order.**

Please complete this form and fax to (360)933-1197. Call our office and our clinical pharmacists will be happy to make therapy recommendations.

Diagnoses:

_____ ICD-10: _____

_____ ICD-10: _____

_____ ICD-10: _____

Medication Orders:

- Medication/Dose: _____ First dose? Yes: ☐ No: ☐ Route: _____
  Instructions: _____ Length of therapy/end date: _____
- Medication/Dose: _____ First dose? Yes: ☐ No: ☐ Route: _____
  Instructions: _____ Length of therapy/end date: _____
- Medication/Dose: _____ First dose? Yes: ☐ No: ☐ Route: _____
  Instructions: _____ Length of therapy/end date: _____

☐ Clinical pharmacist to monitor drug levels and adjust dose accordingly.

- Alteplase 2mg IV to declot central IV access per Infusion Solutions protocol as needed for occlusion.
- Flush line with D5W, 0.9% NaCl and/or Heparin 10 units/ml or 100 units/ml per Infusion Solutions protocol.
- Lidocaine 1% - up to 0.2ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).
- Infusion Reaction Management per Infusion Solutions protocol as needed.

Nursing Orders:

☐ If no central IV access, RN to insert peripheral IV, rotate site every 72 to 120 hours or as needed.

☐ Other: _____

_____

_____

Labs:

☐ CBC with Diff	☐ weekly	☐ every _____
☐ ESR (Erythrocyte Sedimentation Rate)	☐ weekly	☐ every _____
☐ Serum Creatinine	☐ weekly	☐ every _____
☐ ALT	☐ weekly	☐ every _____
☐ CRP	☐ weekly	☐ every _____
☐ CK (for Daptomycin)	☐ weekly	☐ every _____
☐ BMP (Na, K, Cl, CO2, BUN, SCr, Gluc, Ca)	☐ weekly	☐ every _____
☐ CMP (BMP + AST, ALT, TP, Alb, Glob, Alp, Tbil)	☐ weekly	☐ every _____
☐ Hepatic Panel (Alk Phos, Alb, DBil, Tbil, TP, ALT, AST)	☐ weekly	☐ every _____
☐ Other: _____	☐ weekly	☐ every _____

_____ _____

Prescriber Signature *Date*

_____

Please Print Name