MONUMENT HEALTH

* E O R D *

Outpatient Infusion Therapy Orders

Orders are valid for one year from date written unless otherwise specified.

Vendor:
- ☐ Outpatient: Ambulatory Infusion Center
- ☐ Outpatient: Dialysis
- ☐ Home Infusion
- ☐ Other:_____

Diagnosis:
- ☐ Diagnosis:_____

Consults to Providers:
Provider to follow patient:_____ Contact Information:_____

Nursing:

Vital Signs:
- ☑ Vital signs *Routine*
- Other:_____

Call Provider If:
- ☑ Vital Signs *Temperature greater than 38.5 degrees Celsius or _____ degrees Celsius*
  Pulse less than 40 bpm or _____ bpm, Pulse greater than 120 bpm or _____ bpm
  RR less than 12 rpm or _____ rpm, RR greater than 26 rpm or _____ rpm
  SBP less than 75 mmHg or _____ mmHg, SBP greater than 180 mmHg or _____ mmHg
  DBP less than 45 mmHg or _____ mmHg, DBP greater than 100 mmHg or _____ mmHg
- ☐ Other: _____

IV:

Line Care and Flush IV Access per Central Venous Access Devices Policy.
- ☐ Peripheral IV
- ☐ Central Line (e.g. PICC) *Insert if not in place.*
  PICC removal to be pulled on: _____
  Or contact the following Provider for orders: _____
- ☐ Midline
- ☐ Port
- ☐ Not Applicable

Medications:

Refer to Central Line Declotting Alteplase order set.

Infusion Medications:
- *Medical Necessity:*_____
  - ☐ Pharmacy Consult:_____
  - ☐ Medication:_____ Dose:_____
    Route: _____Frequency: _____Duration:_____
  - ☐ Medication:_____ Dose:_____
    Route: _____Frequency: _____Duration:_____
  - ☐ Medication:_____ Dose:_____
    Route: _____Frequency: _____Duration:_____

Premedications: (NOT for Home Infusion):
- *Medical Necessity:* _____
  - ☐ methylPREDNISolone sodium succinate _____ [Dose] intravenously _____ minutes prior to infusion
  - ☐ Acetaminophen (Tylenol®) 650 mg orally _____ minutes prior to infusion
  - ☐ Acetaminophen (Tylenol®) 1000 mg orally _____ minutes prior to infusion
  - ☐ LorATADINE (Claritin®) 10 mg orally _____ minutes prior to infusion
  - ☐ diphenhydrAMINE (Benadryl®) 25 mg orally _____ minutes prior to infusion
  - ☐ diphenhydrAMINE (Benadryl®) 50 mg orally _____ minutes prior to infusion
  - ☐ diphenhydrAMINE (Benadryl®) 25 mg intravenously _____ minutes prior to infusion
  - ☐ diphenhydrAMINE (Benadryl®) 50 mg intravenously _____ minutes prior to infusion
  - ☐ Other _____

Provider Name PRINTED:_____

Provider Signature: _____ Date: _____ Time: _____

Original: PROVIDER ORDERS TAB **FAX** sent to Pharmacy by:_____ Date: _____ Time: _____

Fax this order set to Pharmacy.

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Laboratory:

- *Medical Necessity:*_____

☐ Comprehensive Metabolic CMP *on* _____ *and weekly or* _____
☐ BMP Basic Metabolic Panel *on* _____ *and weekly or* _____
☐ CBC W/O Differential *on* _____ *and weekly or* _____
☐ ESR Erythrocyte Sedimentation Rate *on* _____ *and weekly or* _____
☐ CRP C-Reactive Protein *on* _____ *and weekly or* _____
☐ Other _____

For Follow-Up Labs, send copy to:

☐ PCP: _____
☐ ID: _____
☐ Ortho: _____
☐ Neurosurgery:_____

Provider Name PRINTED:_____

Provider Signature: _____ Date: _____ Time: _____

Original: PROVIDER ORDERS TAB **FAX** sent to Pharmacy by:_____ Date: _____ Time: _____

Fax this order set to Pharmacy.