ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN	
Allergies/Reactions:	Fax all infusions to: 833-380-8800 Please mark the appropriate infusion center: ❑ Allenmore Infusion Center ❑ DHEC Infusion Center ❑ Auburn Infusion Center ❑ North Spokane Infusion Center ❑ Gig Harbor Infusion Services ❑ North Star Lodge Infusion Center ❑ Puyallup Infusion Center
ORDERS WITH CHECK BOXES	When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Antibiotic Infusion Orders

Patient Name: _____ Requested Date of Service: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Patient Phone Number: (_____) _____ - _____ □ May leave message

Diagnosis: **ICD -10 Code:**

□ _____ □_____

Type of IV access: _____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs and documentation ***If required documentation not received with order, scheduling of treatment will be delayed until complete information is available***

Baseline labs required:
□ CBC w/ diff □ BMP/CMP □ CRP □ ESR □ Additional labs_____

Maintenance Labs Required:
□ CBC w/ diff □ BMP/CMP □ CRP □ ESR □ Additional labs_____

Frequency: _____

Treatment Regimen:
Antibiotic_____ Route _____ Dose_____

Frequency_____ Length of therapy: _____

Vital Signs: Check vital signs prior to and at completion of infusion.
Contact provider if systolic BP >180; diastolic BP >100; systolic BP <90; HR >110; temp >38C (100.4F)

If hypersensitivity develops (fever, chills, hypotension, rigors, itching, rash, etc.):
- Consult MultiCare hypersensitivity guideline for treatment management
- Notify provider of reaction, assessment and need for further orders

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: □ Yes □ No (if yes, please send DOCUMENTATION of consent with order)

_____ _____ _____ _____
Provider Signature Print Name Date Time

Orders expire in 12 months**

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-Printed Order

ANTIBIOTIC INFUSION ORDERS (Adults)

MultiCare

60-0695-4 (Rev. 9/24)