

MHS Home/Alternate Site Infusion Services Infusion/Injection Order Set

ALL ORDERS MUST BE SIGNED AND DATED BY PRESCRIBING PROVIDER

Patient Name: _____	DOB: ____/____/____	Weight: _____ lb/kg
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Patient Phone Number: (____) ____-____	Requested Date of Service: ____/____/____
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Patient Allergies: _____

Diagnosis: _____ ICD – 10 Code: _____

- Z45.2: Encounter for adjustment and management of vascular access device
- Z95.828: Presence of other vascular implants and grafts

Additional Requirements: In addition to order, please include H&P with documentation to support diagnosis. Must include ICD-10 Code(s) and supporting labs. **** Emergency phone number for provider _____ (required) ****

Provider Order for Home/Alternate Site Infusion/Injection

ORDERS WITH CHECK BOXES

When an order is optional (those with check boxes), providers are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Pre-Medication(s): Select all that apply:

- Acetaminophen: 650 mg tab/cap by mouth once, 30 minutes prior to infusion (patient may provide own supply)
- Diphenhydramine: 25 mg tab/cap by mouth once, 30 minutes prior to infusion (patient may provide own supply) **OR**
- Loratadine: 10 mg tab/cap by mouth once, 30 minutes prior to infusion (patient may provide own supply)
- Other: _____

Medication: (please indicate medication name, dose, frequency, route of administration, and length of therapy)

Additional Medications for vascular access maintenance:

- 0.9% NaCl (NS) PF flush in 10 mL syringe: Administer 5 – 30 mL IV as needed for establishing and maintaining IV access and for flushing IV line post infusion.
- Heparin: 100 units/mL for port OR 10 units/mL for other central line or midline, 3-5 mL PRN for de-accessing line.
- Cathflo (alteplase) 2 mg: Instill 2 mg (2 mL) into occluded catheter as needed for CVC/CVAD occlusion.

Skilled Nurse to draw labs as follows:

- | | |
|--|------------------|
| <input type="checkbox"/> CBC w/ diff | Frequency: _____ |
| <input type="checkbox"/> CMP | Frequency: _____ |
| <input type="checkbox"/> Other Lab(s): _____ | Frequency: _____ |

CONTINUED ON NEXT PAGE

FOR MHS HOME/ALTERNATE SITE INFUSION SERVICES USE ONLY

Patient Identification:

Name:
MRN:
DOB:

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Skilled Nurse Interventions:

- Admit (first visit) patient to services for home infusion therapy of ordered medication(s).
- Complete Skilled Nurse visit with each infusion/injection for ongoing home infusion therapy of ordered medication(s).
- Obtain vital signs (TPR & B/P) at baseline, with each infusion rate titration, completion of infusion, and after any post-infusion monitoring period.
- Obtain patient weight at each visit.
- For IM/SubQ injections: Inject medication via the ordered route of administration.
- For IV infusions:
 - Establish IV access and flush per policy to maintain patency.
 - Draw labs as ordered.
 - Administer pre-medications as prescribed.
 - Administer medication(s) as prescribed.
 - Once infusion complete, flush IV line with sodium chloride 0.9% (NS) and heparin as prescribed.
- If vital signs are stable after infusion/injection and any observation period, Skilled Nurse will discontinue IV access, if applicable, and complete visit.

If Hypersensitivity Reaction Develops (fever, chills, hypotension, rigors, itching, rash, etc.):

The Skilled Nurse will:

- STOP THE INFUSION, if applicable.
- Administer emergency medications as prescribed (below).
- Contact Emergency Medical Services (EMS/911) if indicated.
- Increase vital sign monitoring to every 5 minutes.
- Contact provider via emergency phone number for additional instructions.
- Notify MHS Home/Alternate Site Infusion Pharmacist AND Nurse Supervisor.

Emergency Medications: To be administered by skilled nurse as needed for hypersensitivity reactions.

- **Diphenhydramine 50 mg/mL solution:** Inject **0.5 mL** (25 mg) into the vein via slow IV push over at least 2 minutes as needed for rash, itching, hives, flushing of skin, and/or mild-to-moderate hypersensitivity reaction. May give IM if no IV access is available.
- **Methylprednisolone sodium succinate (SOLU-MEDROL) 125 mg/2 mL solution:** Inject **2 mL** (125 mg) into the vein as a slow IV push over at least 3 minutes once, as needed for hives, flushing of the skin, shortness of breath, chest tightness, tachycardia (HR>140 bpm), and/or moderate-to-severe hypersensitivity reaction. May give IM if no IV access is available.
- **EPINEPHrine (Adrenalin) 1 mg/mL solution:** Inject **0.3 mL** (0.3 mg) intramuscular every 5-15 minutes as needed (maximum 3 doses) for severe allergic reaction or anaphylaxis AND call 911 and provider.
- **Acetaminophen (Tylenol) 325 mg tab:** Take **2 tablets** (650 mg) by mouth as needed for fever (PRN for temperature > 101F/38.3C) and/or mild-to-moderate hypersensitivity reaction.
- **0.9% NaCl (NS) solution:** Infuse **500 mL** into the vein via gravity as needed at a rate needed to maintain IV access.
- **Oxygen:** Initiate oxygen by RN PRN chest pain or dyspnea to keep SpO₂>90%. For 1-6 LPM, use NC. For 6-10 LPM, use simple mask.

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)

I certify that this patient is safe and appropriate to receive therapy from Home Infusion Services.

Provider Signature: _____ Printed Name: _____ Date: _____

NPI: _____ Orders expire in 12 months unless otherwise specified: _____

Provider/Clinic Information:

Address: _____

Phone #: _____ Fax#: _____

Return completed orders to:

MultiCare Home/Alternate Infusion Services
253-459-6650 (phone) / 253-864-2785 (fax)

FOR MHS HOME/ALTERNATE SITE INFUSION SERVICES USE ONLY

Patient Identification:

Name: _____

MRN: _____

DOB: _____

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