

ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

Fax all infusions to: 833-380-8800 Allenmore Infusion Center DHEC Infusion Center
 Please mark the appropriate 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)**



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