Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO7071

ADULT AMBULATORY INFUSION ORDER

Antibiotic Therapy

(Daptomycin, Vancomycin, & Aminoglycosides)

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.
2. If using this order form to request antibiotics from a home health agency, use a separate order set. May use ambulatory InfuSystem™ pump for antibiotic administration if needed.
3. Order culture and sensitivity tests as necessary.
4. Monitor drug levels and adjust dose as necessary.
    a. DAPTOmycin: draw Creatine Phosphokinase (CPK) - Plasma, Weekly. Monitor CPK more frequently in patients with recent prior or concomitant therapy with an HMG-CoA reductase inhibitor, unexplained CPK increases, or renal impairment
    b. Vancomycin: draw trough level just before the 4th dose and once weekly.
    c. Aminoglycosides: For daily dosing, draw random level 12 hours after the start of infusion and once weekly. For every 8-12 hour dosing, draw peak and trough weekly. Troughs are drawn just before the dose and peaks are drawn 30 minutes after the end of the dose.

NURSING ORDERS:

1. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes

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DAPTOmycin:

LABS:

- ☐ CBC with differential, every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ CMP, every_____(visit)(days)(weeks)(months) – Circle One
- ☐ **CK, PLASMA, ONCE prior to therapy**
- ☐ **CK, PLASMA, weekly during therapy**
- ☐ Labs already drawn. Date: _____

MEDICATION:

- ☐ DAPTOmycin _____ mg/kg = _____ mg in NaCl 0.9% 50 mL IV, over 30 minutes

Interval: (must check one)

- ☐ ONCE
- ☐ Daily x ____ doses
- ☐ Every _____ days x _____ doses

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Vancomycin:

LABS:

- ☐ CBC with differential, every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ CMP, every_____(visit)(days)(weeks)(months) – Circle One
- ☐ **Vancomycin trough, weekly during therapy (first level prior to 4th dose)**
- ☐ Labs already drawn. Date: _____

MEDICATION:

- ☐ Vancomycin 750 mg in NaCl 0.9% 150 mL IV
- ☐ Vancomycin 1000 mg in NaCl 0.9% 250 mL IV
- ☐ Vancomycin 1250 mg in NaCl 0.9% 250 mL IV
- ☐ Vancomycin 1500 mg in NaCl 0.9% 300 mL IV

Infuse doses up to 1000 mg over at least 60 minutes and doses greater than 1000 mg over 120 minutes. Infusion rate not to exceed 17 mg/min

Interval: (must check one)

- ☐ ONCE
- ☐ Daily x ____ doses
- ☐ Every _____ days x _____ doses

Aminoglycosides:

LABS:

- ☐ CBC with differential, every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ CMP, every_____(visit)(days)(weeks)(months) – Circle One
- ☐ **Urine Dipstick w/o micro (10 dip), weekly during therapy**

Daily dosing

- ☐ **Random** _____ **level, 12 hours post-dose, weekly during therapy**

Traditional dosing

- ☐ **Peak** _____ **level, weekly during therapy**
- ☐ **Trough** _____ **level, weekly during therapy**

- ☐ Labs already drawn. Date: _____

MEDICATION:

- ☐ Amikacin _____ mg/kg = _____ mg in NaCl 0.9% 100 mL IV, over 30-60 minutes
- ☐ Gentamicin _____ mg/kg = _____ mg in NaCl 0.9% 100 mL IV, over 30-60 minutes
- ☐ Tobramycin _____ mg/kg = _____ mg in NaCl 0.9% 100 mL IV, over 20-60 minutes

Interval: (must check one)

- ☐ ONCE
- ☐ Daily x ____ doses
- ☐ Every _____ days x _____ doses

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FOR InfuSystem™ AMBULATORY PUMP USE (hook up at infusion location):

Frequency:

- ☐ Q6H
- ☐ Q8H
- ☐ Q12H
- ☐ Daily
- ☐ Once every _____ days
- ☐ Continuous infusion, rate: _____ per ____

Duration:

- ☐ _____ days

By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax**: _____

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OLC Central Intake Nurse:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient's preferred clinic location:

☐ **Beaverton**
OHSU Knight Cancer Institute
15700 SW Greystone Court
Beaverton, OR 97006
Phone number: 971-262-9000
Fax number: 503-346-8058

☐ **NW Portland**
Legacy Good Samaritan campus
Medical Office Building 3, Suite 150
1130 NW 22nd Ave.
Portland, OR 97210
Phone number: 971-262-9600
Fax number: 503-346-8058

☐ **Gresham**
Legacy Mount Hood campus
Medical Office Building 3, Suite 140
24988 SE Stark
Gresham, OR 97030
Phone number: 971-262-9500
Fax number: 503-346-8058

☐ **Tualatin**
Legacy Meridian Park campus
Medical Office Building 2, Suite 140
19260 SW 65th Ave.
Tualatin, OR 97062
Phone number: 971-262-9700
Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders