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

PO7071

ADULT AMBULATORY INFUSION ORDER

Antibiotic Therapy

(Cephalosporin, Fluoroquinolone, and Others)

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, specify interval and duration of therapy at the bottom of the order. May use ambulatory InfuSystem™ pump for antibiotic administration if needed.
3. Order culture and sensitivity tests as necessary.

LABS:

- ☐ CBC with differential, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One
- ☐ CMP, Routine, ONCE, every_____(visit)(days)(weeks)(months) – Circle One
- ☐ Labs already drawn. Date: _____

MEDICATIONS:

Cephalosporins:

- ☐ CeFAZolin 500 mg in NaCl 0.9% 100 mL IV, ONCE over 20-40 minutes
- ☐ CeFAZolin 1 gram in NaCl 0.9% 100 mL IV, ONCE over 20-40 minutes

- ☐ Cefepime 1 gram in NaCl 0.9% 50 mL IV, ONCE over 30 minutes
- ☐ Cefepime 2 grams in NaCl 0.9% 50 mL IV, ONCE over 30 minutes
- ☐ Cefepime ____ grams in NaCl 0.9% ____ mL IV, ONCE continuous infusion

- ☐ CefTAZidime 1 gram in NaCl 0.9% 100 mL IV, ONCE over 15-30 minutes
- ☐ CefTAZidime 2 grams in NaCl 0.9% 100 mL IV, ONCE over 15-30 minutes

- ☐ CefTRIAXone 1 gram in NaCl 0.9% 50 mL IV, ONCE over 30 minutes
- ☐ CefTRIAXone 2 grams in NaCl 0.9% 50 mL IV, ONCE over 30 minutes

Interval: ***(must check one)***

- ☐ ONCE
- ☐ Daily x ____ doses

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Fluoroquinolones:

- ☐ Ciprofloxacin 200 mg in NaCl 0.9% 200 mL IV, ONCE over 60 minutes
- ☐ Ciprofloxacin 400 mg in NaCl 0.9% 200 mL IV, ONCE over 60 minutes

- ☐ Levofloxacin 250 mg in NaCl 0.9% 50 mL IV, ONCE over 60 minutes
- ☐ Levofloxacin 500 mg in NaCl 0.9% 100 mL IV, ONCE over 60 minutes
- ☐ Levofloxacin 750 mg in NaCl 0.9% 150 mL IV, ONCE over 90 minutes

Interval: ***(must check one)***
- ☐ ONCE
- ☐ Daily x ____ doses

Other:

- ☐ Azithromycin 250 mg in NaCl 0.9% 250 mL IV, ONCE over 60 minutes
- ☐ Azithromycin 500 mg in NaCl 0.9% 250 mL IV, ONCE over 60 minutes

- ☐ Clindamycin 600 mg in NaCl 0.9% 50 mL IV, ONCE over 30 minutes
- ☐ Clindamycin 900 mg in NaCl 0.9% 50 mL IV, ONCE over 30 minutes

- ☐ Doxycycline 100 mg in NaCl 0.9% 250 mL IV, ONCE over 60 minutes
- ☐ Doxycycline 200 mg in NaCl 0.9% 250 mL IV, ONCE over 60 minutes

- ☐ Sulfamethoxazole/Trimethoprim 5 mg/kg = _____ mg in **D5W** IV, ONCE over 60-90 minutes

- ☐ **Other (drug, dose, route):** _____
  (Pharmacist to confirm availability)

Interval: ***(must check one)***
- ☐ ONCE
- ☐ Daily x ____ doses

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

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

Duration:
- ☐ _____ days

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NURSING ORDERS:

1. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes
2. In the case of sulfamethoxazole/trimethoprim (BACTRIM), flush IV line with 5 mL D5W before and after each infusion.

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**: _____

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