**Antibiotic Therapy**

(Cephalosporin, Fluoroquinolone, and Others)

|-------------|---------------|------|-----------|

**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
- Ceftepime 1 gram in NaCl 0.9% 50 mL IV, ONCE over 30 minutes
- Ceftepime 2 grams in NaCl 0.9% 50 mL IV, ONCE over 30 minutes
- Ceftepime ____ 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
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
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