Antibiotic Therapy
(Penicillins and Carbapenems)

<table>
<thead>
<tr>
<th>Laboratory Test</th>
<th>Frequency</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBC with differential</td>
<td>Once</td>
<td>Routine, every_____ (visit)(days)(weeks)(months) – Circle One</td>
</tr>
<tr>
<td>CMP</td>
<td>Once</td>
<td>Routine, every_____ (visit)(days)(weeks)(months) – Circle One</td>
</tr>
<tr>
<td>Labs already drawn</td>
<td>Date:</td>
<td></td>
</tr>
</tbody>
</table>

**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. Use Separate order sheet for home infusion
3. 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.
4. Order culture and sensitivity tests as necessary.

MEDICATIONS:

**Penicillins:**

- Ampicillin
  - 1000 mg in NaCl 0.9% 50 mL, intravenous, ONCE over 15-20 minutes
  - 2000 mg in NaCl 0.9% 100 mL intravenous, ONCE over 15-20 minutes

- Nafcillin
  - 1 gram in NaCl 0.9% 100 mL intravenous, ONCE over 30-60 minutes
  - 2 grams in NaCl 0.9% 100 mL intravenous, ONCE over 30-60 minutes
  - _____ grams in NaCl 0.9% _____ mL, intravenous, continuous infusion

**Penicillin G potassium (PFIZERPEN) intravenous**

- _____ million units in NaCl 0.9% 100 mL, ONCE over 1-2 hours
- _____ million units in NaCl 0.9% _____ mL, continuous infusion

**Penicillin G benzathine (BICILLIN L-A) intramuscular**

- 600,000 units as a single dose
- 1.2 million units as a single dose
- 2.4 million units as a single dose

Interval: (must check one)
- ONCE
- Daily x _______ doses
Adult Ambulatory Infusion Order

Antibiotic Therapy (Penicillins and Carbapenems)

Penicillins (continued):

- **Piperacillin/Tazobactam**
  - □ 2.25 grams in NaCl 0.9% 100 mL, intravenous, ONCE over 30 minutes
  - □ 3.375 grams in NaCl 0.9% 100 mL, intravenous, ONCE over 30 minutes
  - □ 4.5 grams in NaCl 0.9% 100 mL, intravenous, ONCE over 30 minutes
  - □ ___________ grams in NaCl 0.9% _____ mL, intravenous, **continuous infusion**

  **Interval:** *(must check one)*
  - □ ONCE
  - □ Daily x ________ doses

Carbapenems:

**OHSU Clinical Knowledge and Therapeutics Executive Committee (CKTEC) restricts ertapenem and meropenem to approval by infectious disease attending**

- **Ertapenem**
  - □ 1 gram in NaCl 0.9% 100 mL, intravenous, ONCE over 30 minutes

- **Meropenem**
  - □ 500 mg in NaCl 0.9% 100 mL, intravenous, ONCE over 15-30 minutes
  - □ 1 gram in NaCl 0.9% 100 mL, intravenous, ONCE over 15-30 minutes

  **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
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