ADULT AMBULATORY INFUSION ORDER
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: __________

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.

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
□ CeFAZolin 6 grams over 1 day in NaCl 0.9% 151.2 mL IV, ONCE over 24 hours, continuous infusion via CADD

□ 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 4 grams over 1 day in NaCl 0.9% 100.8 mL IV, ONCE over 24 hours, continuous infusion via CADD
□ CeFEPime 6 grams over 1 day in NaCl 0.9% 151.2 mL IV, ONCE over 24 hours, continuous infusion via CADD

□ 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):

Duration:
- ________ days
HYPERSENSITIVITY MEDICATIONS:

1. If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (Policy HC-PAT-133-GUD). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.

2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction, Max dose 50 mg

3. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED X 1 dose for hypersensitivity reaction

4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction

5. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity reaction

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