ADULT AMBULATORY INFUSION ORDER

Antibiotic Therapy
(Cephalosporin, Fluoroquinolone, and Others)

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.

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 dextrose 5% before and after each infusion.

MEDICATIONS:

Cephalosporins:
- ceFAZolin 500 mg in sodium chloride 0.9% 100 mL IV, ONCE over 20-40 minutes
- ceFAZolin 1 gram in sodium chloride 0.9% 100 mL IV, ONCE over 20-40 minutes
- ceFAZolin 6 grams over 1 day in sodium chloride 0.9% 151.2 mL IV, ONCE over 24 hours, continuous infusion via CADD (OHSU only)

- ceFEPime 1 gram in sodium chloride 0.9% 50 mL IV, ONCE over 30 minutes
- ceFEPime 2 grams in sodium chloride 0.9% 50 mL IV, ONCE over 30 minutes
- ceFEPime 4 grams over 1 day in sodium chloride 0.9% 100.8 mL IV, ONCE over 24 hours, continuous infusion via CADD (OHSU only)
- ceFEPime 6 grams over 1 day in sodium chloride 0.9% 151.2 mL IV, ONCE over 24 hours, continuous infusion via CADD (OHSU only)
## Antibiotic Therapy

### Cephalosporin, Fluoroquinolone, and Others

<table>
<thead>
<tr>
<th>ACCOUNT NO.</th>
<th>MED. REC. NO.</th>
<th>NAME</th>
<th>BIRTHDATE</th>
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</table>

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

- **cefTAZidime** 1 gram in sodium chloride 0.9% 100 mL IV, ONCE over 15-30 minutes
- **cefTAZidime** 2 grams in sodium chloride 0.9% 100 mL IV, ONCE over 15-30 minutes
- **cefTAZidime** 6 grams over 1 day in sodium chloride 0.9% 151.2 mL IV, ONCE over 24 hours, continuous infusion via CADD (OHSU only)
- **cefTRIAXone** 1 gram in sodium chloride 0.9% 50 mL IV, ONCE over 30 minutes
- **cefTRIAXone** 2 grams in sodium chloride 0.9% 50 mL IV, ONCE over 30 minutes

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

### Fluoroquinolones:

- **ciprofloxacin** 200 mg in sodium chloride 0.9% 200 mL IV, ONCE over 60 minutes
- **ciprofloxacin** 400 mg in sodium chloride 0.9% 200 mL IV, ONCE over 60 minutes
- **levoFLOXacin** 250 mg in sodium chloride 0.9% 50 mL IV, ONCE over 60 minutes
- **levoFLOXacin** 500 mg in sodium chloride 0.9% 100 mL IV, ONCE over 60 minutes
- **levoFLOXacin** 750 mg in sodium chloride 0.9% 150 mL IV, ONCE over 90 minutes

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

### Other:

- **azithromycin** 250 mg in sodium chloride 0.9% 250 mL IV, ONCE over 60 minutes
- **azithromycin** 500 mg in sodium chloride 0.9% 250 mL IV, ONCE over 60 minutes
- **clindamycin** 600 mg in sodium chloride 0.9% 50 mL IV, ONCE over 30 minutes
- **clindamycin** 900 mg in sodium chloride 0.9% 50 mL IV, ONCE over 30 minutes
- **doxycycline** 100 mg in sodium chloride 0.9% 250 mL IV, ONCE over 60 minutes
- **doxycycline** 200 mg in sodium chloride 0.9% 250 mL IV, ONCE over 60 minutes
- **sulfamethoxazole/trimethoprim** 5 mg/kg = ____ mg in dextrose 5% 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 (OHSU only; hook up at infusion location):

Duration: □ __________ days

HYPERSENSITIVITY MEDICATIONS:
1. NURSING COMMUNICATION – 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 (OHSU HC-PAT-133-GUD, HMC C-132). 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 or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion 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: _______________
Central Intake:
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