

ANTIMICROBIAL THERAPY

With Fax Include: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes.

Order Date: ___/___/___

Referral Status: New Referral Dose or Frequency Change Renewal

<p>Patient Name: _____</p> <p>Date of Birth: ___/___/___</p> <p>Weight: ___ kg Height: ___ cm</p> <p>Allergies: _____</p> <p><input type="checkbox"/> NKA</p>	<p>Primary Insurance: _____</p> <p>Member ID: _____</p> <p>Secondary Insurance: _____</p> <p>Member ID: _____</p> <p>Authorization #: _____</p>												
<p style="text-align: center;">Diagnosis</p> <p>Diagnosis Code (ICD-10): _____</p> <p>Indication: _____</p> <p>Target start date: _____</p>	<p style="text-align: center;">Lab Orders</p> <p><input type="checkbox"/> AST/ALT <input type="checkbox"/> BMP <input type="checkbox"/> BUN <input type="checkbox"/> CBC <input type="checkbox"/> CBC + Diff <input type="checkbox"/> CMP</p> <p><input type="checkbox"/> CRP <input type="checkbox"/> CK <input type="checkbox"/> Creatinine (serum) <input type="checkbox"/> Sed rate</p> <p><input type="checkbox"/> Other: _____</p> <p style="text-align: center;">Frequency</p> <p><input type="checkbox"/> Daily <input type="checkbox"/> Weekly (Mon) <input type="checkbox"/> Once</p> <p><input type="checkbox"/> Other: _____</p>												
<p>Pre-medications: No pre-medications are routinely given. Pre-medications may be ordered at physician discretion.</p> <p><input type="checkbox"/> _____</p>													
<p>Antimicrobial Therapy:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top; border: none;"> <input type="checkbox"/> Cefepime _____ g IVP [Max Once Daily Dosing]</td> <td style="width: 50%; vertical-align: top; border: none;"> <input type="checkbox"/> Pen. G benzathine (Bicillin-LA) _____ mill units IM</td> </tr> <tr> <td style="border: none;"> <input type="checkbox"/> Ceftriaxone _____ g IVP</td> <td style="border: none;"> <input type="checkbox"/> Dalbavancin _____ mg IVPB</td> </tr> <tr> <td style="border: none;"> <input type="checkbox"/> Daptomycin _____ mg IVPB</td> <td style="border: none;"> <input type="checkbox"/> Rezafungin: _____ mg IVPB</td> </tr> <tr> <td style="border: none;"> <input type="checkbox"/> Ertapenem _____ g IVPB</td> <td style="border: none;"> <input type="checkbox"/> Other: _____</td> </tr> <tr> <td style="border: none;"> <input type="checkbox"/> Micafungin _____ g IVPB</td> <td></td> </tr> <tr> <td style="border: none;"> <input type="checkbox"/> Vancomycin _____ g IVPB</td> <td></td> </tr> </table> <p><input type="checkbox"/> Pharmacy to Dose</p> <p>Frequency:</p> <p><input type="checkbox"/> Once <input type="checkbox"/> Daily x ___ days <input type="checkbox"/> Weekly x ___ dose(s) <input type="checkbox"/> Other schedule: _____</p>		<input type="checkbox"/> Cefepime _____ g IVP [Max Once Daily Dosing]	<input type="checkbox"/> Pen. G benzathine (Bicillin-LA) _____ mill units IM	<input type="checkbox"/> Ceftriaxone _____ g IVP	<input type="checkbox"/> Dalbavancin _____ mg IVPB	<input type="checkbox"/> Daptomycin _____ mg IVPB	<input type="checkbox"/> Rezafungin: _____ mg IVPB	<input type="checkbox"/> Ertapenem _____ g IVPB	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Micafungin _____ g IVPB		<input type="checkbox"/> Vancomycin _____ g IVPB	
<input type="checkbox"/> Cefepime _____ g IVP [Max Once Daily Dosing]	<input type="checkbox"/> Pen. G benzathine (Bicillin-LA) _____ mill units IM												
<input type="checkbox"/> Ceftriaxone _____ g IVP	<input type="checkbox"/> Dalbavancin _____ mg IVPB												
<input type="checkbox"/> Daptomycin _____ mg IVPB	<input type="checkbox"/> Rezafungin: _____ mg IVPB												
<input type="checkbox"/> Ertapenem _____ g IVPB	<input type="checkbox"/> Other: _____												
<input type="checkbox"/> Micafungin _____ g IVPB													
<input type="checkbox"/> Vancomycin _____ g IVPB													
<p><input checked="" type="checkbox"/> THGH Standard of Care Protocol for IV Access/Line Management and Emergency Medications for Allergic Reactions.</p>													
<p><input type="checkbox"/> Other Orders:</p>													

Provider Name: _____

Office Phone Number: _____

Provider Signature: _____

Office Fax Number: _____

Attending Physician Name: _____ (If ordering provider is an advanced practice practitioner, attending physician required)

Note: This order is valid for 12 months from date of physician signature.



ANTIMICROBIAL THERAPY ORDER SET

The following Standard of Care Protocol has been approved for use in the Infusion Clinic at Trinity Health Grand Haven.

INTRAVENOUS ACCES AND LINE CARE PROTOCOL

Type of Intravenous Line	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Peripheral Access. <ul style="list-style-type: none"> <input checked="" type="checkbox"/> May leave Peripheral Access in place if consecutive Infusions are ordered (greater than or equal to daily) <input checked="" type="checkbox"/> PICC Line <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Discontinue PICC Line at the end of Infusion Therapy <input checked="" type="checkbox"/> Implanted Port <ul style="list-style-type: none"> <input checked="" type="checkbox"/> De-access Port if Infusions are less than or equal to weekly. De-access port at end of Infusion Therapy <input checked="" type="checkbox"/> Midline Catheter <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Discontinue Midline at the end of Infusion Therapy <input checked="" type="checkbox"/> Central Line (Non-tunneled) <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Discontinue Central Line at the end of Infusion Therapy
Line Care	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Peripheral Access: Scrub the positive pressure injection cap(s) with alcohol for 30 seconds prior to accessing the line. <input checked="" type="checkbox"/> All other Access types: Scrub the positive pressure injection cap(s) with chlorhexidine for 15 seconds prior to accessing the line. If allergic to chlorhexidine, use betadine scrub for 30 seconds prior to accessing line. <input checked="" type="checkbox"/> All Access types: Change dressing every 7 days and PRN if soiled or non-occlusive <input checked="" type="checkbox"/> Biopatch to all Access types except Peripheral Access <input checked="" type="checkbox"/> If Implanted Port, change Huber needle with dressing change every 7 days.
Line Flushing	<p>Flushing protocol</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Peripheral Access flush with 3mL of 0.9% sodium chloride <i>before</i> and <i>after</i> each medication administration <input checked="" type="checkbox"/> All other access types: Flush with 10mL 0.9% sodium chloride <i>before</i> and <i>after</i> each medication administration or 20 mL 0.9% sodium chloride after blood draw <input checked="" type="checkbox"/> Flush capped lumens with 10mL 0.9% sodium chloride daily if lumen not in use. <input checked="" type="checkbox"/> Implanted Port: When de-accessing, flush with 10mL 0.9% sodium chloride and follow with 5mL of Heparin 100u/mL.
General Care	<p>For all Access types except Peripheral Access</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> May use Line for lab draws <input checked="" type="checkbox"/> Minimum of 5 mL of blood to be withdrawn and wasted prior to obtaining blood samples, administering medications or flushing port. <input checked="" type="checkbox"/> Only 10 mL size syringe to be used to withdraw samples or flush catheter.
Occlusion	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> If unable to flush line, administer Alteplase (Cath-Flo) 2mg <input checked="" type="checkbox"/> If unable to flush line, notify Physician of occlusion <input checked="" type="checkbox"/> STAT portable chest x-ray after insertion Reason: Line Placement Confirmation



ANTIMICROBIAL THERAPY ORDER SET

EMERGENCY MANAGEMENT OF ALLERGIC REACTIONS PROTOCOL	
Vital Signs	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Vital Signs: if patient has suspected Allergic Reaction: Every 5 Minutes until stable then every 15 Minutes until symptoms resolve. <input checked="" type="checkbox"/> Pulse Oximetry: for suspected Allergic Reaction, initiate pulse oximetry monitoring until symptoms resolve.
Oxygen	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Oxygen PRN adjust to maintain O2 Sat greater than 90%
Cardio-pulmonary	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> ECG STAT if complaint of chest pain or difficulty breathing <input checked="" type="checkbox"/> Albuterol 2.5mg/3mL (0.003%) Nebulizer Treatment STAT PRN wheezing, bronchospasm, hypoxemia, dyspnea. Administer with oxygen. May repeat treatment Q10 Minutes for a total of 3 doses. <input checked="" type="checkbox"/> SVN
Medications	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> 0.9% Sodium Chloride 500mL IVPB STAT PRN hypotensive management (SBP less than 90mmHg or MAP less than 60). Infuse over 30 Minutes. Notify Physician for further orders. <input checked="" type="checkbox"/> Acetaminophen (Tylenol) 650mg PO x1 dose PRN generalized pain, back pain, abdominal cramping, headache, or temperature greater than 100.5°F <input checked="" type="checkbox"/> Famotidine (Pepcid) 20mg IV PUSH STAT x1 Dose PRN Allergic Reaction Severity Grade 3. Administer over 2 Minutes. Notify Physician for further orders <input checked="" type="checkbox"/> Diphenhydramine (Benadryl) 50mg IV PUSH STAT x1 dose PRN Allergic Reaction Severity Grade 3. If patient has severe hypotension, administer after hypotensive episode is resolved. Use with caution in patient over 60 years of age or history of asthma. Notify Physician for further orders <input checked="" type="checkbox"/> Diphenhydramine (Benadryl) 25mg IV PUSH STAT x1 dose PRN Allergic Reaction Severity Grade 2. Use with caution in patient over 60 years of age or history of asthma. Notify Physician for further orders <input checked="" type="checkbox"/> Hydrocortisone 100mg IV PUSH STAT x1 PRN Allergic Reaction Severity Grade 3. Notify Physician for further orders <input checked="" type="checkbox"/> Epinephrine (EPI-PEN) 0.3mg/0.3mL IM STAT PRN Allergic Reaction Severity Grades 3-4 or Anaphylaxis. May repeat Q15 Minutes x2 doses. Notify Physician for further orders <p style="margin-top: 10px;"><i>Based on the CoFAR Grading System for Systemic Allergic Reactions Version 3.0</i></p>

Per CMS survey and Certification group memo dated 8/11/2021, "the use of standing orders must be documented as an order in the patient's medical record and signed by the practitioner responsible for the care of the patient, but the timing of such documentation should not be a barrier to effective emergency response, timely and necessary care, or other patient safety advances.

