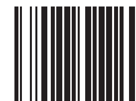
WHEN DRUG FORMULA AND DOSAGE ARE IDENTICAL, THE PHARMACY MAY DISPENSE THE DRUG WHICH IS IN HOSPITAL STOCK REGARDLESS OF TRADE NAME UNLESS I SPECIFICALLY REQUEST "NO SUBSTITUTE." PHYSICIAN MUST DELETE ORDERS NOT DESIRED (DRAW A SINGLE LINE THROUGH THE ORDER). (IF BLANKS NOT FILLED IN, ORDERS CONSIDERED DELETED.) ***Orders not to be initiated without physician signature and/or physician telephone authorization.***



1PO

DO NOT WRITE OUTSIDE OF BORDER AREA

HOME IV ANTIBIOTICS ORDER - PEDIATRICS AND NICU

SW/DCP Name:________________ Phone________ Pager__________

****

Information fax to vendor by SW/DCP: [check when done] **Date Faxed**_____ **by**__________

☐ Patient Demographic Sheet ☐ History & Physical ☐ Medication Sheet

☐ Lab result if available

Primary Diagnosis

ht _____ in / cm wt _____ Kg ALLERGIES ________________

IV Therapy Order to be completed by LIP:

1) MEDICATION &/OR IV FLUIDS **START DATE:** __________

Name of Medication	Dosage	Frequency	Duration of Therapy

2) ACCESS DEVICE ☐ **Peripheral** ☐ **PICC** ☐ **Neo-PICC** [ATTN: Home Health RN, do not change dressing or remove PICC]

Brand______ Size ___ Site ______ Dressing changes per protocol ☐ Yes ☐ No

Catheter mark at skin cm (FOR PICC) Additional comment: ________________

3) LAB ORDERS ☐ **Draw Peripherally** ☐ **Heel Stick** ☐ **Draw via PICC Line**

Additional comment: ________________

4) HOME HEALTH ORDER

☐ Total # of home health skilled nursing visits recommended______

☐ Home Infusion Company RN to teach family prior to discharge from the hospital

☐ Home Infusion Company RN to monitor first dose infusion at home

☐ Home Infusion Company to coordinate additional home health visits with other agency/agencies to monitor:

☐ wt check ☐ hydration ☐ medication teaching ☐ site infection

☐ wound care ☐ blood draw ☐ other _______

Name of Home Health agency (Home Infusion Company to select)________________

****

LIP PRINTED NAME:_______ PHONE: __________ PAGER: ______

LICENSE #: _______ NPI:__________ CLINIC #:______

NAME OF VENDOR: _______ PHONE: __________ FAX:______

DATE:_____ TIME:_____ LIP SIGNATURE: __________ ID #: _____

Colby Campus • 1321 Colby Ave.
Pacific Campus • 916 Pacific Ave.
Pavilion for Women and Children • 900 Pacific Ave.
Providence Regional Cancer Partnership
1717 13th Street • Everett, WA 98201

HOME IV ANTIBIOTICS ORDER - PEDIATRICS AND NICU (03/11)

31474 (04/15/11)

PLACE PATIENT LABEL HERE

Patient Name:________________

Birthdate: ________________