INFUSION SUITE ORDER SET

1PO

Plan Start Date: _____/ _____/_____

Ordering Provider:

Line Type, Access, Care and Maintenance

☐ Place peripheral access ☐ Insert PICC ☐ Access Port ☐ Access PICC

☒ Care and maintenance per protocol of selected vascular access device.

Labs

☐ BMP	Priority _____	Interval _____	Duration _____
☐ CBC	Priority _____	Interval _____	Duration _____
☐ CMP	Priority _____	Interval _____	Duration _____
☐ Vanco Trough	Priority _____	Interval _____	Duration _____
☐ _____	Priority _____	Interval _____	Duration _____
☐ _____	Priority _____	Interval _____	Duration _____

Pharmacy may order additional Labs as needed for dosing / monitoring purposes.

Pre-Medication Order

☐ Acetaminophen (Tylenol) PO Tablet Dose _____ Frequency _____

☐ Diphenhydramine (Benadryl) PO Tablet Dose _____ Frequency _____

☐ _____ Route _____ Dose_____ Frequency _____

Hydration

☐ Normal Saline 0.9%	Dose _____	Rate _____	Frequency_____	# of Doses_____
☐ Lactated Ringers	Dose _____	Rate _____	Frequency_____	# of Doses_____
☐ _____	Dose _____	Rate _____	Frequency_____	# of Doses_____

LIP Signature: _____ID#_____ Date: _____ Time: _____

DO NOT WRITE OUTSIDE OF BORDER AREA

PROVIDENCE
Regional Medical Center
Everett

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

60155 (1/29/18)

PLACE PATIENT LABEL HERE

Patient Name:_____

Birthdate: _____

INFUSION SUITE ORDER SET

1PO

Medication

☐ **Pharmacy to dose**

☐ Cefepime IV	Dose _____	Rate _____	Frequency_____	# of Doses_____
☐ Ceftriaxone IV	Dose _____	Rate _____	Frequency_____	# of Doses_____
☐ Daptomycin IV	Dose _____	Rate _____	Frequency_____	# of Doses_____
☐ Ertapenem IV	Dose _____	Rate _____	Frequency_____	# of Doses_____
☐ Meropenem IV	Dose _____	Rate _____	Frequency_____	# of Doses_____
☐ Vancomycin IV	Dose _____	Rate _____	Frequency_____	# of Doses_____
☐ Gancyclovir IV	Dose _____	Rate _____	Frequency_____	# of Doses_____
☐ Tysabri IV	Dose _____	Rate _____	Frequency_____	# of Doses_____
☐ Nulogix IV	Dose _____	Rate _____	Frequency_____	# of Doses_____
☐ Remicade IV	Dose _____	Rate _____	Frequency_____	# of Doses_____
☐ Reclast IV	Dose _____	Rate _____	Frequency_____	# of Doses_____
☐ Magnesium IV	Dose _____	Rate _____	Frequency_____	# of Doses_____
☐ Solumedrol IV	Dose _____	Rate _____	Frequency_____	# of Doses_____
☐ _____	Dose _____	Rate _____	Frequency_____	# of Doses_____
☐ _____	Dose _____	Rate _____	Frequency_____	# of Doses_____

Nursing communication: _____

_____

_____

_____

_____

_____

LIP Signature: _____ID#_____ Date: _____ Time: _____

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