Pre-Printed Orders for
HOME I.V. THERAPY

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DRUG & FOOD ALLERGIES

- Mandatory □ Optional: Prescriber check (✓) to initiate, cross out and initial any orders not indicated.

Admission Date: ___________________________ MRP: _____________________________

Patient Information: DIAGNOSIS: _____________________________

Wt (kg): ___________________________ Relevant Med Hx: _____________________________

Ht (cm): ___________________________

MEDICATION(S):

□ ceFAZolin ___________ mg IV Q ___ H
□ cefTRIAxone ___________ mg IV Q ___ H
□ CLINDAMYCIN ___________ mg IV Q ___ H
□ CLOXACILLIN ___________ mg IV Q ___ H
□ ERTAPENEM ___________ mg IV Q ___ H
□ GENTAMICIN ___________ mg IV Q ___ H
□ IMIPENEM ___________ mg IV Q ___ H
□ VANCOMycin ___________ mg IV Q ___ H
□ Other (specify) ___________________________

Duration of Therapy: ___________________________

LAB WORK:

□ CBC, electrolytes, Serum Creatinine (if not done within 48 hours of admission into program)
□ Pharmacist to order drug levels and dose adjust as required
   □ GENTAMICIN: ___________________________
   □ VANCOMycin: ___________________________
   □ Other (specify): ___________________________

Weekly lab work:

□ Serum Creatinine
□ Other (specify): ___________________________

IV ACCESS ASSESSMENT AND SPECIAL REQUIREMENTS:
(IVHP RN to complete)

Type of Line: □ PICC line
□ Peripheral line
□ Other (specify): ___________________________

Type of Pump: □ CADD (continuous infusion)
□ STAT 2 Pumpette (intermittent infusion)
□ Gravity (intermittent infusion)

Medication manufacturing requirements:

□ Air out (24 hour bag)
□ Other (specify): ___________________________

Date (dd/mm/yyyy) Time Prescriber Signature Printed Name or College ID#