fraserhealth

# Pre-Printed Orders for
# HOME I.V. THERAPY

DRDO102510B Rev: Feb 2012 Page: 1 of 1

DRUG & FOOD ALLERGIES

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

Admission Date: _____ MRP: _____

Patient Information:
Wt (kg): _____
Ht (cm): _____

DIAGNOSIS: _____

Relevant Med Hx: _____

## 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# |
|---|---|---|---|
| | | | |