PHYSICIAN'S ORDERS FOR HOME INFUSION THERAPY

Patient Name: ________________ **DOB:** ________ **Weight:** ______ kg **Height:** ______ cm
Diagnosis: ________________
Allergies (Including OTC/Herbal): ________________

Current IV Access: ____ Peripheral IV ____ Central Line (Single / Double / Triple Lumen – Circle One) ____ PICC ____ Midline
____ Port (Needle Size____________ Accessed on _____________)

Medications:	**Drug**	**Dose**	**Route**	**Frequency**	**Length of Therapy**	
					Start Date/Time:	/
					Stop Date/Time:	/
					Start Date/Time:	/
					Start Date/Time:	/
					Start Date/Time:	/
					Stop Date/Time:	/
					Start Date/Time:	/
					Stop Date/Time:	/
Yes No	*** Medications to be administered with continuous intermittent programmable pump with 1 ml per hour to keep vein open.**					

CCHH Flush Protocol Orders: **(Check flush protocol for this patient.)**	☐ **PIV**: Flush PIV with NS (2-5 ml) before and after medication, followed by Heparin flush (10 units/ml) 1 ml IV as a final flush. If medication is given once daily, flush PIV with heparin flush (10 units/ml) 1 ml IV every 12 hours. ☐ **Midline, PICC line, Central Venous Catheters (single, double, or triple lumen)**: Flush line with NS (2-5 ml) before and after medication, followed by Heparin flush (100 units/ml) 3 ml IV after completion of medications (no more frequently than every 4 hours) or daily for capped lines. ***For patients that weigh 10 kg or less, Heparin flush (10 units/ml) 1 ml IV.*** ☐ **Port**: Flush port with NS (3-5 ml) before and after medications, followed by Heparin flush (100 units/ml) 3 ml IV after completion of medications (no more frequently than every 4 hours & prior to removal of needle).
Other Flush Orders:	**Flush with NS ______ ml before / after / or in-between medications.**
	Flush with D5W ______ ml before / after / or in-between medications. (Amphotericin / Gamunex / Bactrim / IV *GCSF)
	Flush with Heparin (10 units/ml) (50 units/ml) (100 units/ml) ______ ml after NS flush.

YES	**NO**	**NA**	**Change Midline / PICC** / Central Line dressings every 7 days and PRN. Last changed on: _______________ (Date)**
YES	**NO**		**Skilled nursing visit to instruct in administration of IV therapy.**
YES	**NO**		**Skilled nursing visit to administer IV therapy.**
YES	**NO**	**NA**	**Maintain peripheral IV as long as site is healthy.**
YES	**NO**	**NA**	**Restart peripheral IV as needed to maintain access for therapy.**
YES	**NO**	**NA**	**Re-access port every 3-7 days at: Home / Clinic**
***GCSF - Granulocyte Colony Stimulating Factors**			****PICC - Peripherally Inserted Central Catheter**

Labs:

CBC / ESR / BUN / Creatinine / Lytes (Circle) every: ________________ Home / Clinic
________________ **Peak / Trough (Circle) with** ____________ **dose**
Repeat : ________________
Acceptable Range for: Trough: __________ Peak: __________
Other Labs: ________________
Contact Person: ________________ **Phone # / Pager:** ________________

Anakit Medications: (Oral Diphenhydramine and Epipen or Epipen Jr.)

1) **Oral Diphenhydramine** 12.5 mg / 5 ml (unit dose cup): Give __________ ml (dose to be calculated at 1.25 mg / kg) as needed for rash, itching, or hives related to medication.
2) **Epipen Jr.** (Weight less than or equal to 30 kg) **Epipen 0.3 mg** (Weight greater than 30 kg)
If patient experiences wheezing, difficulty breathing and swelling of eyes, eyelids or lips, stop infusion immediately and notify your physician and contact your local emergency services.

(Check One): ☐ **Yes** – Send Anakit Medications ☐ **No** – Do Not Send Anakit Medications

DR. SIGNATURE-PRODUCT SELECTION PERMITTED	DATE/TIME	DR. SIGNATURE-DISPENSE AS WRITTEN	DATE/TIME

Discharging floor, please fax these orders to: ________________

CookChildren's Home Health