PRGORD Progress & Order

PeaceHealth

Peace Harbor Medical Center
Outpatient Infusion Service Request

Phone: (541) 902-6019 Fax: (541) 902-1649

Thank you for selecting our infusion services team to care for your patient. If you are not a PeaceHealth provider, all information listed below is required before we can process orders and schedule your patient for treatment.

Part A- Patient scheduling and contact information:

Patient Name (Last, First): _____Date of Birth: _____

Patient Contact Information and Phone Number (s): _____

Ordering Provider Name (Print): _____

Provider Clinic or Service Address: _____

Clinic or Service Phone Number: _____ Clinic or Service Fax Number: _____

Diagnosis (include ICD 10 codes): _____

Medication and Service Requested- list J-Code/ CPT code if known: _____

Date Service is Requested to Begin: _____ **Date Service is Expected to End**: _____

Order will expire 1 year from date of provider signature unless "date service is expected to end" is earlier.

Part B- Insurance and Prior Authorization. Any non-PeaceHealth provider must obtain prior authorization prior to service. *Attach a copy of authorization documentation received from insurance payer when submitting orders.*

Insurance (Payer) Company: _____

Prior Authorization Number and Conditions: _____

Prior Authorization Expiration Date: _____

Insurance (Payer) Contact Phone Number: _____

Part C- Elements needed to guide medication therapy are included with request for service:

☐ All orders and instruction (please use the PeaceHealth approved ordering form) are complete and include provider signature AND printed name at the bottom of each order page. Check the boxes of ALL orders you would like to activate.

☐ For blood products, PeaceHealth Blood and Transfusion Consent form is signed and dated by the provider and the patient.

If information is located outside of PeaceHealth's electronic medical record system attach the following:

☐ A list of current medications reconciled by patient provider is available and includes a list of known allergies.

☐ Recent progress notes from ordering provider.

☐ A copy of relevant laboratory results and other appropriate supporting documentation.

IMPORTANT MESSAGE TO PROVIDERS: To reduce delays in treatment and phone calls to your office you may participate in the PHMC formulary process by signing this document. A clinical pharmacist will adjust orders according to PHMC approved policies and procedures.

> *I agree to utilize PHMC policies & procedures that have been reviewed by the Pharmacy & Therapeutics Committee and authorized by the Medical Executive Committee of PHMC. This agreement will be issued for the duration of active orders contained within this treatment plan.*

PROVIDER SIGNATURE: _____ DATE: _____ TIME:_____

FAX completed service request and completed orders to: PHMC OP Infusion and Nursing Services 541-902-1649

Patient Identification Label

PeaceHealth
Peace Harbor Medical Center

DAPTOmycin (Cubicin)
Outpatient Infusion Therapy Plan

All Pre-Selected Boxed Orders Are Initiated by Default Unless Crossed Out by Practitioner. All Boxed Orders Require Practitioner Check to be Initiated.

Heading	Content
For Admission to Service	**Provider Instruction –** please select applicable reason for ordering (required): ☐ Failed vancomycin therapy ☐ ID Consult ☐ Other reason: _____
Labs	☒ CBC with automated differential once prior to beginning treatment and weekly. ☒ CMP once prior to beginning treatment and weekly. ☒ CPK once prior to beginning treatment and weekly. ☐ ESR once prior to beginning treatment and weekly. ☐ CRP once prior to beginning treatment and weekly. ☒ Provider approves to release and draw labs 2 days pre and post this planned treatment date. ☐ Fax lab results to: Provider _____Fax Number _____
Supportive Care	☒ **DAPTOmycin (Cubicin) IV infusion in NS 50 ml every 24 hours over 30 minutes.** **Select Dose:** ☐ 6 mg/kg ☐ _____ mg/kg ☒ Pharmacist may round the calculated dose to the nearest 50 mg increment. ☒ Pharmacist to adjust interval as needed for renal function.
Nursing Orders	☒ Obtain patient weight prior to beginning treatment and weekly. ☒ RN to notify provider if CPK > 1000 units/L with unexplained signs and symptoms of myopathy and/or if CPK > 2000 units/L.
Nursing IV Access and Maintenance	**Select the most appropriate option below:** ☒ **Insert PERIPHERAL IV** as needed and flush (unless provider selects option for a central line). ☒ Sodium chloride 0.9% (NS) flush 10 mL IV once as needed for line care. ☐ **Access and use NON-PICC Central Line/CVAD** ☒ Initiate Central Line (non-PICC) maintenance protocol. ☒ Sodium chloride 0.9% (NS) flush 10 mL IV as needed for line care, before and after medication administration, at discharge, and at de-access (sterile NS for Port-a-Cath access). ☒ Sodium chloride 0.9% (NS) flush 20 mL IV as needed for line care post lab draw. ☒ Heparin, porcine (PF) 100 unit/mL flush 5 mL IV as needed for line care, for de-access. ☐ **Access and use PICC Central Line/CVAD** ☒ Initiate PICC maintenance protocol. ☒ Change PICC line dressing weekly and as needed. ☒ Sodium chloride 0.9% (NS) flush 10 mL IV as needed for line care, and before and after medication administration. ☒ Sodium chloride 0.9% (NS) flush 20 mL IV as needed for line care post lab draw
As Needed Medications	**Standard As Needed Medications:** ☒ Sodium chloride 0.9% (NS) flush 10 mL IV as needed for line care. ☒ Sodium chloride 0.9% 500 mL continuous infusion at 25 mL/hour IV as needed for therapy administration (i.e., blood products, chemotherapy, potassium administration). ☒ Alteplase (Cathflo) injection 2 mg intra-catheter as needed for occluded central line catheters- Retain in catheter for 30 minutes to 2 hours; may instill a second dose if occluded. IRRITANT.

Practitioner Signature: _____Date of Order: _____Time: _____

Final page of orders must include signature of the ordering practitioner, date, and time.

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Heading	Content
Emergency Medications	**If patient has symptoms of anaphylaxis (wheezing, dyspnea, hypotension, angioedema, chest pain, or tongue swelling), discontinue infusion and initiate standard emergency response procedures.** **Standard Adult Emergency Medications:** ☒ **DiphenhydrAMINE (Benadryl) injection** 25-50 mg IV once as needed for mild to moderate drug reactions (flushing, dizziness, headache, diaphoresis, fever, palpitations, chest discomfort, blood pressure changes (>/= 20 points in SBP), nausea, urticaria, chills, pruritis). • Administer 50 mg IV if patient has NOT had diphenhydramine within 2 hours of reaction. • Administer 25 mg IV if patient has had diphenhydramine within 2 hours of reaction, if reaction doesn't resolve in 3 minutes may repeat 25 mg IV dose for a total of 50 mg and contact provider. ☒ **Albuterol 90 mcg/actuation inhaler** 2 puffs once as needed for wheezing, shortness of breath associated with infusion reaction and contact provider. Administer with a spacer if available. ☒ **MethylPREDNISolone (Solu-Medrol) injection** 125 mg IV once as needed for shortness of breath for continued symptoms of mild to moderate drug reactions (flushing, dizziness, headache, diaphoresis, fever, palpitations, chest discomfort, blood pressure changes (>/= 20 points in SBP), nausea, urticaria, chills, pruritic) that worsen or persist after administration of diphenhydramine (Benadryl) and contact provider. ☒ **EPINEPHrine (Adrenalin) injection** 0.5 mg IM once as needed for severe drug reaction (flushing, dizziness, headache, diaphoresis, fever, palpitations, chest discomfort plus blood pressure changes (>/= 40 points in SBP), shortness of breath with wheezing and 02 Sat < 90%) and contact provider.
Referral	☒ Ambulatory referral to OP Infusion Services
PHMC Outpatient Infusion Contact Information	**PROVIDER – PLEASE SIGN, DATE AND TIME ORDERS AND RETURN TO:** **PeaceHealth Peace Harbor Medical Center Outpatient Infusion Services Department** 400 Ninth Street Florence, OR 97439 Contact Phone: 541-902-6019 and FAX ***541-902-1649***
Authorization by Verbal or Telephone Order	Person giving verbal or telephone order: _____ Person receiving verbal or telephone order: _____ ☐ Check to indicate verbal or telephone orders have been read back to confirm accuracy

Practitioner Signature: _____Date of Order: _____Time: _____

Final page of orders must include signature of the ordering practitioner, date, and time.