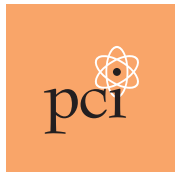


HOME INFUSION



SPECIALTY PHARMACY



NUCLEAR PHARMACY

Infusion Therapy Order

Patient Name: _____ M F Date of Birth: _____
 Address: _____ Patient Phone: _____
 Insurance Info: _____ Medicare Other ID# _____
 Emergency Contact: _____ Contact Phone: _____
 Diagnosis: _____ Height: _____
 Allergies: _____ Weight: _____

Medication Orders:

- Flush Line with 0.9% NS pre and post medication and/or Heparin 10 units/ml or 100 units/ml per protocol as final flush
- Alteplase 2 mg IV to de clot central IV access per protocol as needed for occlusion
- Supplies for external drug infusion pump, per cassette or bag if needed

Medication/Dose: _____ Route: IV SQ Other: _____

Frequency/Instructions: _____ Duration of therapy: _____ TBD

Medication/Dose: _____ Route: IV SQ Other: _____

Frequency/Instructions: _____ Duration of therapy: _____ TBD

Medication/Dose: _____ Route: IV SQ Other: _____

Frequency/Instructions: _____ Duration of therapy: _____ TBD

First Time Dose in Home: (if needed)

Anaphylactic Kit and Orders per Protocol:

Adverse reaction medications to be maintained in the patient's home & administered as necessary:

- Diphenhydramine 50 mg IV x 1 dose
- Epinephrine 1:1000 IM x 1 dose
- 500 ml of NS IV x 1 dose

Nursing Orders:

- If no central IV access, RN may insert peripheral IV, rotate site as needed
- Weekly Lab Work CBC w/Diff CMP CRP ESR Other: _____
 CPK Vanco Trough Aminoglycoside Trough Aminoglycoside Peak
- Other: _____

Physician Signature: _____ Date of Signature: _____

Physician Printed Name: _____

MD Office Contact Name: _____ Phone: _____