PNS-9058-FRM
REV 3 5.26.23

Ambulatory Infusion Center Orders
Conway Medical Center

Scheduling Call: 843-234-5474 and/or 843-347-1586

Fax Orders: 843-234-5460

Name: _____ DOB: _____

Medication Allergies: _____

Height: _____ Weight: _____ Diagnosis: _____

Please include H&P.

___ PIV ___ PICC/Midline/Port ____ Remove PICC/Midline on _____

___ Access Central line for administration lab draws ___ NS Flush

___ heparin flush 100 units/mL 5 mL Intracatheter flush once monthly or prior to deaccess

___ Labs _____ every_____ ____ Fax lab results to: _____

Antibiotic Infusions:

*Indication for use (required): _____

- Cefazolin _____ mg IV every _____hours x_____
- Cefepime _____ mg IV every _____hours x_____
- Ceftaroline/Teflaro _____ mg IV every _____hours x_____
- Ceftriaxone (Rocephin) _____ mg IV every _____hours x_____
- Daptomycin (Cubicin) _____ mg IV every _____hours x_____
- Gentamicin _____ mg IV every _____hours x_____
- Ertapenem _____ mg IV every _____hours x_____
- Meropenem _____ mg IV every _____hours x_____
- Vancomycin _____ mg IV every _____hours x_____
- Zosyn _____ mg IV every _____hours x_____
- Other: _____

Rheumatology / GI Infusions

PreMeds:

- Tylenol 650 mg po
- Benadryl 25 mg po
- Benadryl 25 IV

PreMeds:

- Cetirizine 10 mg po
- Solumedrol ____mg IV
- Other: _____

- Remicade _____ mg IV every _____Weeks(s)
- Inflectra _____ mg IV every _____Weeks(s)
- Renflexis _____ mg IV every _____Weeks(s)
- Avsola _____ mg IV every _____Weeks(s)

- Actemra (tocilizumb) _____ mg IV every _____Weeks(s)

Other Infusions / Transfusion

- Blood Transfusion _____ Units _____ over _____ hours
  - Type and Screen _____ Cross and Match _____
- ACTH Stimulation Test
  - Cosyntropin 0.25 mg, IV Push Once
  - Cortisol Level Baseline
  - Cortisol Level 30 min post injection
  - Cortisol Level 1 Hour post injection
- Albumin 25% 12.5 gms IV Piggyback every 30 minutes x _____ doses
- Orencia _____ mg IV every _____Weeks(s)
- Simponi Aria _____ mg IV every _____Weeks(s)
- Reclast 5 mg IV Piggyback every _____Weeks(s)
- IV Fluids
  - Normal Saline _____ mL IV at _____ mL/hr x ___ bags
- Iron:
  - Injectafer 750 mg given IV x _____ Dose(s) 7 days apart, infuse over ____ minutes
  - Venofer _____ mg over _____ minutes x _____ Dose (s)
- Tepezza _____ mg IV every _____Weeks(s)
- Ocrevus _____ mg IV every _____Weeks(s)
- Other _____

Adverse Reaction Protocol:

Mild to Moderate Infusion Reaction

hyperemia, palpitations, diaphoresis, headache, dizziness, nausea, urticarial, hypo/hypertension (>= 20 points above pre-treatment systolic BP), chest discomfort, shortness of breath, elevated temperature

- Stop Infusion
- Pulse Oximetry Continuous
- diphenhydrAMINE 25 mg, IV Push, Once, PRN. May repeat x1 dose for itching, flushing, or urticaria
- acetaminophen 650 mg, Oral, Once, PRN fever > 38C. Notify Provider
- Call provider for mild to moderate infusion reaction
- Monitor vital signs q 10 min until WNL- Wait 20 min then restart infusion at lower rate

Infusion Reaction Severe

Severe Infusion Reaction = significant hypo/hypertension (>= 40 points above pre-treatment systolic BP), elevated temperature with rigors, hyperemia, chest discomfort, respiratory rate >= 20 or stridor.

- Stop Infusion - DO NOT restart infusion until patient seen by provider
- normal saline bolus 1,000 mL, IV Bolus, Rate = 999 mL/hr, Once, PRN Severe infusion reaction
- Oxygen Therapy Flow Rate 2 L/min, Nasal Cannula, for shortness of breath or wheezing
- Vital Signs every 2 minutes until WNL
- Call provider for severe infusion reaction
- diphenhydrAMINE 25 mg, IV Push, Once, PRN Severe infusion reaction. May repeat x1 dose for itching, flushing or urticaria
- acetaminophen 650 mg, Oral, Once, PRN fever > 38C
- EPINEPHrine 0.3 mg, IM, Once, May repeat x1 in 15 minutes PRN wheezing, stridor or anaphylaxis

- hydrocortisone 100 mg, IV Push, Once, PRN rash or itching
- meperidine 25 mg, IV Push, Once, PRN Rigors if no hypotension

Special orders:

_____

_____

_____

Provider Printed Name: _____

Provider Signature: _____

Date: _____ Time: _____

Facility Contact Number: _____