Corewell Health™

Patient Name	
DOB	
MRN	
Physician	
CSN	

Physician's Orders
ANTIBIOTIC (INTRAVENOUS/INTRAMUSCULAR) - ADULT, OUTPATIENT, COREWELL HEALTH INFUSION CENTER

Corewell Health Site of Service (select one):

☐ **Blodgett Hospital**
1840 Wealthy St. NE
Grand Rapids, MI 49506
Phone: 616.391.0351
Fax: 616.391.8969

☐ **Gerber Hospital**
230 West Oak St.
Fremont, MI 49412
Phone: 231.924.1305
Fax: 231.924.1798

☐ **Greenville Hospital**
615 S. Bower St.
Greenville, MI 48838
Phone: 616.225.9330
Fax: 616.754.4043

☐ **Helen DeVos Children's Hospital**
100 Michigan St. NE
Grand Rapids, MI 49503
Phone: 616.267.1925
Fax: 616.267.1005

☐ **Lemmen Holton Cancer Pavilion** 145 Michigan St. NE
Grand Rapids, MI 49503
Phone: 616.486.6099
Fax: 616.486.6415

☐ **Ludington Hospital**
1 Atkinson Dr.
Ludington, MI 49431
Phone: 231.845.5085
Fax: 231.845.5025

☐ **Neuro Infusion ICCB**
2750 E Beltline Ave NE
Grand Rapids, MI 49525
Phone: 616.391.0351
Fax: 616.391.8669

☐ **Pennock Hospital**
1009 W. Green St.
Hastings, MI 49058
Phone: 269.798.6762
Fax: 269.798.6763

☐ **Reed City Hospital**
4499 220th Ave.
Reed City, MI 49677
Phone: 231.832.7105
Fax: 231.832.0915

☐ **Zeeland Hospital**
8333 Felch St.
Zeeland, MI 49464
Phone: 616.748.3640
Fax: 616.748.3690

☐ **Brownstown Infusion Clinic**
19725 Allen Rd. Suite 101
Brownstown Twp, MI 48183
Phone: 734.479.2371
Fax: 734.479.2451

☐ **Dearborn Hospital**
18101 Oakwood Blvd.
Dearborn, MI 48124
Phone: 313.593.5913
Fax: 313.593.8551

☐ **Farmington Hills Hospital Botsford**
28050 Grand River Ave.
Farmington Hills, MI 48336
Phone: 947.521.8174
Fax: 248.471.8217

☐ **Grosse Pointe Infusion Clinic**
21400 E 11 Mile Rd.
Saint Clair Shores, MI 48081
Phone: 586.498.4498
Fax: 586.498.4497

☐ **Lenox Infusion Clinic**
36555 6 Mile Rd.
Lenox, MI 48048
Phone: 947.523.4060
Fax: 947.523.4061

☐ **Livonia Infusion Clinic**
39000 7 Mile Rd. Suite 1000
Livonia, MI 48152
Phone: 947.523.4360
Fax: 734.542.3356

☐ **Royal Oak**
3601 W 13 Mile Rd.
Royal Oak, MI 48073
Phone: 248.898.1000
Fax: 248.551.3168

☐ **Troy Hospital**
44344 Dequindre Rd. Suite 230
Sterling Heights, MI 48314
Phone: 248.964.3080
Fax: 248.964.2409

☐ **Wayne Hospital**
33155 Annapolis St.
Wayne, MI 48184
Phone: 734.467.2556
Fax: 734.467.2505

☐ **Marie Yeager Cancer Center**
3900 Hollywood Rd.
Saint Joseph, MI 49085
Phone: 269.556.7180
Fax: 269.556.7185

☐ **Niles Infusion**
42 N St. Joseph Ave Ste 303
Niles, MI 49120
Phone: 269.684.6140
Fax: 269.683.8744

☐ **Watervliet Hospital**
400 Medical Park Dr.
Watervliet, MI 49098
Phone: 269.463.2310
Fax: 269.463.0012

PATIENT INFORMATION:

Name: First _____ Middle _____ Last _____

Date of birth _____ Phone (_____) _____

Address _____

City _____ State _____ Zip code _____

REFERRAL: Infusion Therapy

Referring Physician (print) _____

Office: Phone (_____) _____ Fax (_____) _____

Direct line for urgent questions about patient (_____) _____

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NOTE: Epic Treatment/Therapy Plan Orders. To be scanned/attached to the appropriate Infusion Referral Order in Epic.

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Infusions:

Anticipated Infusion Date: _____ **ICD-10 Code with Description:** _____

Height _____ (cm) Weight _____ (kg) Allergies _____

Labs to be collected:

☐ CBC w/ Differential
- ☐ Once
- ☐ Every visit
- ☐ _____

☐ BMP
- ☐ Once
- ☐ Every visit
- ☐ _____

☐ CMP
- ☐ Once
- ☐ Every visit
- ☐ _____

☐ C Reactive Protein (CRP), Blood Level
- ☐ Once
- ☐ Every visit
- ☐ _____

☐ Creatine Kinase (CK) Level
- ☐ Once
- ☐ Every visit
- ☐ _____

☐ Sedimentation rate
- ☐ Once
- ☐ Every visit
- ☐ _____

☐ Antibiotic Trough Blood Level ☐ Amikacin ☐ Gentamicin ☐ Tobramycin ☐ Vancomycin
- ☐ Once
- ☐ Every visit
- ☐ _____

☐ Antibiotic Peak Blood Level ☐ Amikacin ☐ Gentamicin ☐ Tobramycin
- ☐ Once
- ☐ Every visit
- ☐ _____

☐ Additional lab order(s) _____
- ☐ Once
- ☐ Every visit
- ☐ _____

Hydration:

☐ Sodium chloride 0.9% _____ mL, IV, Administer over _____ minutes

Pre-medications:

☐ Acetaminophen (TYLENOL) PO Once ☐ 325 mg ☐ 500 mg ☐ 650 mg ☐1000 mg

☐ DiphenhydrAMINE (BENADRYL) PO Once ☐ 25 mg ☐ 50 mg

☐ Additional pre-medications: _____

Treatment:

Frequency:
- ☐ Once
- ☐ Every 24 hours
- ☐ Every _____ hours
- ☐ Every _____ days

Duration:
- ☐ # of treatments _____
- ☐ # of days _____
- ☐ Until date: _____

☐ Discontinue PICC – May remove PICC line at the end of treatment

Select Desired IV Antimicrobial for Infusion

Cephalosporins

☐ **CeFAZolin (ANCEF) IV**
- ☐ 500 mg ☐ 2 g
- ☐ 1 g ☐ 3 g
- ☐ 1.5 g

☐ **Cefepime (MAXIPIME) IV**
- ☐ 500 mg
- ☐ 1 g
- ☐ 2 g

☐ **Ceftaroline (TEFLARO) IV**
- ☐ 200 mg
- ☐ 400 mg
- ☐ 600 mg

☐ **CefTAZidime (FORTAZ) IV**
- ☐ 500 mg ☐ 2 g
- ☐ 1 g

☐ **CefTRIAXone (ROCEPHIN) IV**
- ☐ 1 g
- ☐ 2 g

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Carbapenems

☐ **Ertapenem (INVANZ) IV**
- ☐ 500 mg
- ☐ 1000 mg

☐ **Meropenem (MERREM) IV**
- ☐ 500 mg ☐ 2 g
- ☐ 1 g

Glycopeptides

☐ **Dalbavancin (DALVANCE) IV**
- ☐ 500 mg
- ☐ 1000 mg
- ☐ 1500 mg

☐ **Oritavancin (KIMYRSA)**
- ☐ 1200 mg

☐ **Vancomycin (VANCOCIN) IV**
- ☐ 500 mg ☐ 1250 mg ☐ 2000 mg
- ☐ 750 mg ☐ 1500 mg ☐ 2250 mg
- ☐ 1000 mg ☐ 1750 mg ☐ 2500 mg

Aminoglycosides

☐ **Amikacin (AMIKIN) IV**
- ☐ 5 mg/kg
- ☐ 7.5 mg/kg
- ☐ 10 mg/kg

☐ **Gentamicin (GARAMYCIN) IV**
- ☐ 1 mg/kg ☐ 5 mg/kg
- ☐ 1.5 mg/kg ☐ 7 mg/kg
- ☐ 2 mg/kg

☐ **Tobramycin (NEBCIN) IV**
- ☐ 5 mg/kg
- ☐ 7 mg/kg

Antifungals

☐ **Micafungin (MYCAMINE) IV**
- ☐ 50 mg
- ☐ 100 mg
- ☐ 150 mg

☐ **Rezafungin (REZZAYO) IV**
- ☐ 400 mg
- ☐ 200 mg

Other Antimicrobials

☐ **Aztreonam (AZACTAM) IV**
- ☐ 3 g
- ☐ 6 g

☐ **DAPTOmycin (CUBICIN) IV**
- ☐ 6 mg/kg
- ☐ 8 mg/kg
- ☐ 10 mg/kg

☐ **LevoFLOXacin (LEVAQUIN) IV**
- ☐ 250 mg
- ☐ 500 mg
- ☐ 750 mg

☐ **Tigecycline (TYGACIL) IV**
- ☐ 50 mg
- ☐ 100 mg

Select Desired IM Antibiotic for Injection

☐ **Cefepime (MAXIPIME) IM**
- ☐ 1 g

☐ **CefTRIAXone (ROCEPHIN) IM**
- ☐ 250 mg
- ☐ 500 mg
- ☐ 1 g

☐ **Ertapenem-lidocaine IM**
- ☐ 1 g
- ☐ 1000 mg

☐ **Penicillin G benzathine IM**
- ☐ 2.4 million units

Select Desired Antibiotic for continuous (over 24 hours) IV Home Infusion via CADD Pump

☐ **Nafcillin (Nallpen) IV**
- ☐ 6 g
- ☐ 9 g
- ☐ 12 g

☐ **Oxacillin IV**
- ☐ 6 g
- ☐ 9 g
- ☐ 12 g

☐ **Penicillin G potassium IV**
- ☐ 12 million units
- ☐ 18 million units
- ☐ 20 million units
- ☐ 24 million units

☐ **Vancomycin (Vancocin) IV**
- ☐ 1000 mg
- ☐ 2000 mg
- ☐ 30 mg/kg

☒ ONC NURSING COMMUNICATION 5
Discontinue infusion and remove home infusion pump

☒ Discontinue PICC
May remove PICC line at the end of treatment

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Supplemental Orders

The following orders will be applied to the patient's plan unless otherwise indicated

Appointment Requests

☒ **Infusion Appointment Request**
Status: Future, Expected: S, Expires: S+365, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after infusion and possible labs.

Provider Reminder

☒ **ONC PROVIDER REMINDER 20**
Routine, Until discontinued Starting when released Until Specified
Ensure that after last treatment that patient has APPOINTMENT TO REMOVE CADD pump

Safety Parameters and Special Instructions

☒ **ONC NURSING COMMUNICATION 103**
Contact Provider for increased stool production (4 or more above baseline) per day (24 hours) or moderate increase in ostomy output.

☒ **ONC NURSING COMMUNICATION 2**
Routine, Until discontinued Starting when released Until Specified
If patient has any symptoms of a hypersensitivity reaction, immediately stop medication infusion and obtain vital signs. Maintain IV patency with 0.9% sodium chloride at 10 mL/hour.

Vitals

☒ **Vital Signs**
Routine, PRN Starting when released Until Specified. Take vital signs at initiation and completion of infusion

Nursing Orders

☒ **ONC NURSING COMMUNICATION 100**
May Initiate IV Catheter Patency Adult Protocol

☒ **ONC NURSING COMMUNICATION 22**
If patient has PICC line, please draw labs from PICC line

☒ **Hypersensitivity Reaction Adult Oncology Protocol**
Until discontinued Starting when released Until Specified

Telephone order/Verbal order documented and read-back completed. Practitioner's initials _____

NOTE: Unless Order is written DAW (dispense as written), medication may be supplied which is a generic equivalent by nonproprietary name.

TRANSCRIBED:		VALIDATED:		ORDERED:		
TIME	DATE	TIME	DATE	TIME	DATE	Pager #
	Sign		R.N. Sign		Physician Print	Physician Sign

EPIC VERSION DATE: 07/16/20