Spectrum Health

Physician's Orders
AMPHOTERICIN AMBISOME - ADULT, OUTPATIENT, INFUSION CENTER

Patient Name
DOB
MRN
Physician
FIN

Defaults for orders not otherwise specified below:
- ☐ Interval: once
- ☐ Interval: Every ___ days

Duration:
- ☐ Until date: _____
- ☐ 1 year
- ☐ _____# of Treatments

Anticipated Infusion Date_____ ICD 10 Code with Description_____

Height_____(cm) Weight_____(kg) Allergies_____

Provider Specialty

☐ Allergy/Immunology	☐ Infectious Disease	☐ OB/GYN	☐ Rheumatology
☐ Cardiology	☐ Internal Med/Family Practice	☐ Other	☐ Surgery
☐ Gastroenterology	☐ Nephrology	☐ Otolaryngology	☐ Urology
☐ Genetics	☐ Neurology	☐ Pulmonary	☐ Wound Care

Site of Service

☐ SH Gerber	☐ SH Lemmen Holton (GR)	☐ SH Pennock	☐ SH United Memorial
☐ SH Helen DeVos (GR)	☐ SH Ludington	☐ SH Reed City	☐ SH Zeeland

Appointment Requests

☑ Infusion Appointment Request
Status: Future, Expected: S, Expires: S+366, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Infusion and possible labs

Nursing Orders

☑ ONC NURSING COMMUNICATION 100
May Initiate IV Catheter Patency Adult Protocol

Vitals

☑ Vital Signs
Routine, PRN, Starting S, Take vital signs at initiation and completion of infusion and as frequently as indicated by patient's symptoms

Labs

		Interval	Duration
☐	Complete Blood Count w/Differential	☐ Every ___days ☐ Once	☐ Until date: _____ ☐ 1 year ☐ _____# of Treatments
	Status: Future, Expected: S, Expires: S+184, URGENT, Clinic Collect, Blood, Blood, Venous		
☐	Basic Metabolic Panel (BMP)	☐ Every ___days ☐ Once	☐ Until date: _____ ☐ 1 year ☐ _____# of Treatments
	Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous		
☐	Comprehensive Metabolic Panel (CMP)	☐ Every ___days ☐ Once	☐ Until date: _____ ☐ 1 year ☐ _____# of Treatments
	Status: Future, Expected: S, Expires: S+184, URGENT, Clinic Collect, Blood, Blood, Venous		
☐	C Reactive Protein (CRP), Blood Level	☐ Every ___days ☐ Once	☐ Until date: _____ ☐ 1 year ☐ _____# of Treatments

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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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Labs (continued)

	Interval	Duration
Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous		
☐ Creatine Kinase (CK), Blood Level	☐ Every ___days ☐ Once	☐ Until date: _____ ☐ 1 year ☐ _____# of Treatments
Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous		
☐ Sedimentation rate	☐ Every ___days ☐ Once	☐ Until date: _____ ☐ 1 year ☐ _____# of Treatments
Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous		
☐ Other Labs: _____	☐ Every ___days ☐ Once	☐ Until date: _____ ☐ 1 year ☐ _____# of Treatments

Hydration

☑ sodium chloride 0.9% bolus injection

Dose:
☐ 100 ml
☐ 500 ml
☐ 1000 ml
☐ 2000 ml
Intravenous, for 60 Minutes, Once, Starting H, For 1 Doses
Administer 60 minutes prior to infusion.

Pre-Medications

☑ acetaminophen (TYLENOL) tablet 650 mg

650 mg, Oral, Once, Starting H+30 Minutes, For 1 Doses
Administer 30 to 60 minutes prior to infusion.

☑ diphenhydrAMINE (BENADRYL) capsule

Dose:
☐ 25 mg
☐ 50 mg
Oral, Once, Starting H+30 Minutes, For 1 Doses
Administer 30 to 60 minutes prior to infusion

Medications

☑ dextrose 5% flush 5 mL

5 mL, Intravenous, Once, Starting H+60 Minutes, For 1 Doses
Flush line with dextrose 5% PRIOR to administration of amphotericin B liposomal (AMBISOME)

☑ amphotericin B (liposomal) (AMBISOME) IV

Intravenous, for 2 Hours, Once, Starting H+60 Minutes, For 1 Doses
Dose:
☐ 3 mg/kg
☐ 4 mg/kg
☐ 5 mg/kg
☐ 6 mg/kg
Flush before and after dose with dextrose 5%

☑ dextrose 5% flush 5 mL

5 mL, Intravenous, Once, Starting H+180 Minutes, For 1 Doses
Flush line with dextrose 5% AFTER administration of amphotericin B liposomal (AMBISOME)

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