



THE UNIVERSITY OF KANSAS HOSPITAL 3901 Rainbow Boulevard Kansas City, Kansas 66160	Do not write in this box  D T 0 0 1 7	PATIENT LABEL
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		ORDERS OUTPATIENT INFUSION THERAPY CLINIC PHYSICIAN ORDER FORM <i>(Expires 6 months from initiation date)</i>
		Legend: <ul style="list-style-type: none"> • Bullets indicate orders will be done. Draw one line through any orders that are not needed. <input type="checkbox"/> Boxes are optional and must be checked to be considered an order.
		Reference: _____
		Allergies: _____ Patient Weight in kg: _____
	1.	Attending Physician: _____ Pager: _____ Resident Physician: _____ Pager: _____
	2.	Diagnosis: _____ ICD 9Code: _____ Indications: _____
	3.	Vital signs: <input type="checkbox"/> At the beginning and end of infusion <input type="checkbox"/> Other: _____
	4.	Nursing orders: <ul style="list-style-type: none"> • Assess for any medication reaction after last infusion. • Insert saline lock. If any of the following life threatening hypersensitivity reactions occur: <ul style="list-style-type: none"> • Urticaria • Angioedema • Bronchospasm • Acute respiratory distress syndrome • Myocardial infarction • Ventricular fibrillation • Cardiogenic shock • Anaphylaxis <input type="checkbox"/> Other: _____ <ul style="list-style-type: none"> • STOP the infusion immediately • Administer reaction management medications • Call rapid response/code team as appropriate • Page the ordering physician
	5.	Notify physician if: <ul style="list-style-type: none"> • Temperature > 38.5° C • Pulse < 60 or > 120 BPM • Respirations < 12 or > 35 Breaths per minute • SaO₂ < 92% or increased O₂ needs • SBP < 90 or > 160; DBP < 50 or > 100; MAP of 60 • Any new onset of the following: facial flushing, chills, pruritus, chest pain, and rash. <input type="checkbox"/> POC Glucose <60 or >300 mg/dL
	6.	Labs to be drawn prior to infusion:
	7.	Diagnostics: must list reason for test <input type="checkbox"/> PCXR Reason: _____ <input type="checkbox"/> CXR PA and Lateral Reason: _____

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(Page 1 of 2)



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PATIENT LABEL

PHYSICIAN'S ORDER FORM

ORDERS

OUTPATIENT INFUSION THERAPY CLINIC PHYSICIAN ORDER FORM

(Expires 6 months from initiation date)

DATE
&
TIME

#

Medications:

Pre-medication orders:

- Dexamethasone (Decadron) _____ mg IV prior to infusion.
- Methylprednisolone (Solumedrol) 125 mg IV prior to infusion.
- Acetaminophen (Tylenol) 500 mg po 30 minutes prior to infusion.
- Loratadine (Claritin) 10 mg po 30 minutes prior to infusion.
- Ibuprofen _____ mg po 30 minutes prior to infusion.
- Diphenhydramine (Benadryl) 25mg IV prior to the infusion.

IV Fluids:

- Flush IV site with 10mL NS prior to the infusion and at the completion of the infusion.
- _____

8.

Medications: (orders not to exceed 6 months)

- _____ IV TRO _____ minutes, Q _____ X _____
- _____

PRN Medications:

Reaction Management:

- Acetaminophen (Tylenol) 500 mg po Q 4 hours prn myalgias or fever > 38.5°C
- Diphenhydramine (Benadryl) 25 mg IV Q 4 hours prn urticaria, pruritus, or shortness of breath.
- Oxygen by nasal cannula 2 liters/minute prn chest pain or dyspnea.
- If symptoms are rapidly progressing or continue after the diphenhydramine, give epinephrine (1:1000 strength) 0.3 mL subcutaneously. May repeat every 10-15 minutes to a maximum of 6 doses. (The EpiPen is 0.3 mL IM to be administered in the thigh)

9.

- DC IV and discharge home.

Physician Signature: _____ Pager: _____ Date: _____ Time: _____

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(Page 2 of 2)