vitalcare® INFUSION SERVICES of SIOUX FALLS

PLEASE ATTACH PATIENT DEMOGRAPHIC AND INSURANCE INFORMATION

PATIENT DEMOGRAPHICS			
PATIENT NAME	**DOB**	**HEIGHT** in	**WEIGHT** kg
DIAGNOSIS	**PHONE #**	**ALLERGIES** Include OTC/herbal	
PRIMARY INSURANCE		**PRIMARY INSURANCE #**	
EMERGENCY CONTACT		**PHONE #**	

THERAPY INFORMATION			
ORDERING PROVIDER		**PHONE #**	
FOLLOWING PROVIDER		**PHONE #**	
EXISTING IV ACCESS	☐ **Central Line** (Tunneled/Non-tunneled) ☐ **Peripheral IV** ☐ **Port:** Needle size _____ Accessed_____ ☐ **Midline:** _____lumen ☐ **PICC:** _____ lumen ☐ **Other:**		

PROVIDER ORDERS*

	DRUG	DOSE	ROUTE	FREQUENCY	THERAPY LENGTH	QUANTITY	START DATE	STOP DATE
MEDICATION	☐ **Cubicin®**	6 mg/kg	IV	q 24 hours		#QS		
	☐ **Invanz®**	1 gram	IV	q 24 hours		#QS		
	☐ **Vancomycin**	1000 mg	IV	q 12 hours		#QS		
	☐ **Ceftriaxone**	2 grams	IV	q 24 hours		#QS		
	☐		IV	q _____		#QS		
	☐			q _____		#QS		

FLUSH PROTOCOL (Select one)	☐ **Peripheral IV (PIV)**	Flush with 0.9% NaCl (5 mLs) before and after medication, followed by heparin lock (10 units/mL) 5 mLs as a final lock (SASH) # QS
	☐ **Midline, PICC, Central Venous Catheters** (Single, double, triple lumen)	Flush with 0.9% NaCl (10 mLs) before and after medication, followed by heparin lock (10 units/mL) 5 mLs after completion of medications (SASH); Flush additional lumen with 0.9% NaCl (10 mLs) followed by heparin lock (10 units/mL) 5 mLs once daily #QS
	☐ **Port**	Flush port with 0.9% NaCl (10 mLs) before and after medications, followed by heparin lock (100 units/mL) 5 mLs after completions of medications #QS
	☐ **Other:**	
SUPPLIES	☐ **Supplies and pumps** necessary to maintain and administer medication	
ANAPHALYXIS KIT	☐ **Anaphylaxis Kit:** Diphenhydramine 50 mg (1 vial); Epinephrine 1:1000 (2 vials); Supplies for administration • **Allergic response** - As per provider order: Diphenhydramine 50 mg slow IV push over 2-3 minutes • **Anaphylaxis** - As per provider order: Diphenhydramine 50 mg slow IV push over 2-3 minutes **OR** deep IM injection; Epinephrine 1:1000 solution: 0.4 mg (0.4 mL) subcutaneous injection; If needed, may repeat in 20 minutes times 1 dose	
IV ACCESS MAINTENANCE	☐ **IV therapy administration** by skilled nursing personnel ☐ **Patient education** on administration of IV therapy performed during skilled nursing visit ☐ **Peripheral IV site** to remain on condition site viable; Restart upon any level of pain/tenderness, changes in skin color or temperature, edema, induration, fluid leakage/drainage, or other abnormality and as needed to maintain therapy access ☐ **Subcutaneous port re-access** every 7 days and as needed at home or clinic ☐ **Dressing change** every 7 days and as needed; change immediately if damp, loosened, or visible soiled	

LABS	**Perform weekly lab draw on Mondays, as follows:**	**Lab draw per:** (Select one) ☐ Home Health ☐ Clinic	**Lab orders:** (Select all that apply) ☐ CBC ☐ BMP ☐ BUN ☐ CPK ☐ CRP ☐ ESR ☐ CBC w/diff ☐ CMP ☐ Creatinine ☐ Other: _____ ☐ _____ trough, via peripheral venipuncture, prior to _____ dose then weekly **Fax lab results to:** ☐ Vital Care of North Texas ☐ Providers office

*Product selection permitted unless dispense as written checked or clearly written on order

☐ **DISPENSE AS WRITTEN**

PROVIDER SIGNATURE **DATE/TIME**

1020 S Cliff Ave., Sioux Falls, SD 57104
P/ 605-220-7824
www.vitalcaresiouxfalls.com

Name: _____ Date of Birth: _____ Date: _____

PICC Line placement for long-term antibiotics

Dx:

_____ _____

Dispense as written Substitution Permitted

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