Palmetto Infusion Services

MRN:_____

Phone: 800-809-1265 DOB: _____

Standard Plan of Treatment for 1st Dosing of Anti-Infective

(Re)Certification Period from _____ to _____

Note: We may require MD office notes and may require a letter of Medical Necessity (depending on diagnosis), to be able to verify eligibility and payment for this treatment through patients Medicare and/or other insurance plan.

Patient's Name _____ HT: _____ Weight: _____ Allergies: _____

Primary Diagnosis:

- ☐ Primary: _____
- ☐ Secondary: _____

Orders:

Obtain weight each visit. Vital signs baseline, every 30 minutes during infusion, and 30 minutes after infusion complete. Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. Assess patient response to therapy. Utilize existing central line for administration, or initiate a peripheral IV with each infusion, prn. Normal Saline Flush 5-10ml before and after infusion followed by Heparin Lock 1-5ml 100 units/ml as needed per line type. Pump, tubing and supplies needed to complete prescribed therapy. **If adverse drug reaction, Implement the Standing Adverse Reaction protocol.**

Dose:

Drug: _____ to infuse over _____ minutes

Other:

Pharmacist to perform necessary clinical drug monitoring

(No Stamped Signatures Please)

Physicians Signature: _____ _____ Date: _____

(Dispense as written) (Substitution Permitted)

Print Physician Name: _____

PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION TO 866-872-8920