# OUTPATIENT INFUSION ORDER

ALLERGIES *(required)*

REACTIONS *(required if patient has an allergy)*

ALLERGIES

REACTIONS

DATE/TIME

## PATIENT STATUS = OUTPATIENT

**DIAGNOSIS:** *(required)*

**ORDER EXPIRATION DATE:**
(SIX MONTHS MAX)

**ORDER:** (Name of Medication, Dose, Route and Frequency):

- ***Patient weight:*** _____ Kg ***height:*** _____
- **PRE-SCREENING (required):**
  **Hepatitis B Panel** completed on _____ *(Please attach documentation of results)*

- **PRE-MEDICATION**: **(Choose from selection):** Administer after establishing an IV access
  - ☐ acetaminophen 650 mg PO ONCE, every visit
  - ☐ diphenhydramine 25 mg PO ONCE, every visit
  - ☐ Dexamethasone____ mg PO ONCE, every visit
  - ☐ diphenhydramine 50 mg PO ONCE, every visit
  - ☐ Other:_____

- **MEDICATION:** *(Must check to select a medication)*
  - ☐ Rituximab ☐ Rituximab-***abbs*** ☐ Rituximab-***pvvr***

  _____ mg IV infuse per Rx protocol;

  Repeat infusion _____ weeks for total _____ treatment.

- **NURSING ORDERS:**
  - ❖ Obtain Vital Signs:
    - ▪ Upon arrival
    - ▪ Prior to start of infusion
    - ▪ With each rate titration
    - ▪ At the end of infusion

*Date: *Time: *Sign: MD#:

**RBV**
Initials:

MEDICATIONS WILL BE PROCESSED ACCORDING TO THE GENERIC / THERAPEUTIC EQUIVALENT OR STANDARD PROCEDURES APPROVED BY THE PHARMACY AND THERAPEUTICS COMMITTEE. DEVIATIONS MUST BE SPECIFIED BY "DO NOT SUBSTITUTE."

Salinas Valley HEALTH
450 East Romie Lane, Salinas, CA 93901
831-757-4333 | Toll-free 888-755-7864

NS 7176-035940 (Rev. 10/24)

TIME & DATE REQUIRED

POINFOP

**OUTPATIENT INFUSION ORDER**



***NAME:**

***Date of Birth (DOB):**

# OUTPATIENT INFUSION ORDER

ALLERGIES

REACTIONS

ALLERGIES

REACTIONS

DATE/TIME

## PATIENT STATUS = OUTPATIENT

**DIAGNOSIS:**

**ORDER EXPIRATION DATE:**
(SIX MONTHS MAX)

**ORDER: (Name of Medication, Dose, Route and Frequency):**

***Select type of line:**

☐ **PICC Line** ***Discontinue*** PICC line on:

- Flush each lumen with 5 ml of Heparin 10 units/ml (50 units) IV prior to discharge. May use Saline flush as an alternative for Heparin allergy.
- Change PICC line dressing every 7 days (3 days if using gauze dressing) and PRN soiled or wet.

☐ **Implanted Port**

- Access port and flush each lumen with 5 ml of Heparin 100 units/ml (500 units) IV prior to de-accessing port. May use Saline flush as an alternative for Heparin allergy.

☐ **Tunneled CVC**

- Flush each lumen with 10 mL Normal Saline daily
- Change dressing every 7 days (2 days if using gauze dressing) and PRN soiled, wet, or no longer occlusive.

☑ **Peripheral Line** insert and discontinue prior to discharge.

☑ **For clotted PICC Line or Implanted Port:** Use Alteplase (Cathflo Activase) 2 mg IV ONCE for each line as needed to de-clot lumen(s). May repeat x1 for each lumen, if unable to de-clot the first time.

☑ **Insert peripheral line for hypersensitivity reactions and administer SVH medication as indicated.**

- Diphenhydramine 50 mg IV push x 1 PRN hives, itching, flushing, swollen lips or tongue
- Famotidine 20 mg IV push x 1 PRN hives, itching, flushing swollen lips or tongue
- Albuterol inhaler 2 puffs PRN SOB, tachypnea or decreased oxygen saturation
- Epinephrine 0.3 mg (Epi-Pen) IM may repeat x 2 at 5 min intervals PRN bronchial constriction (dyspnea, wheezing, stridor), hypotension
- Methylprednisolone 125 mg IV push PRN hypersensitivity reaction, to prevent biphasic reaction
- Meperidine 25 mg IV x 1 PRN rigors
- Oxygen Protocol PRN for SOB, tachypnea
- Acetaminophen 650 mg PO PRN fever/chills x 1 (if not given as pre-med)
- Montelukast 10 mg PO PRN wheezing, cough, hives, flushing x 1
- Normal Saline 1000 mg Start at TKO for medication administration, Bolus for SBP < 30 mmHg difference from baseline.

*Date: *Time: *Sign: MD#:

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