Northwestern Medicine®

Infusion Therapy Medication Administration

Order Processing: Fax Form: **CDH PTC: Fax (630) 933-2444** *Phone (630)933-6272* **Delnor OPIC: Fax (630)208-3467** *Phone (630)208-4446*		
Patient Name:	**DOB:**	**MRN** ***(if known)***
Height: cm	**Weight:** kg	
Allergies (list all with reactions):		

Diagnosis and Code REQUIRED for submitting form

Diagnosis:_____Code:_____

Please complete all applicable fields to avoid any delays in scheduling or phone calls for clarification.

Attention provider: Prior to signing orders you will need to define the dose, the interval, and the number of treatments. Patient to start treatment on: (Date) _____

Medication	Dose	Interval	# of Treatments

Attention provider: Nursing to enter a future lab orders prior to discharge for the following: circle all that apply and define the frequency for the lab draw (example: daily, prior to each infusion, weekly {Monday, Tuesday, Wednesday, Thursday, Friday}, every other week, once a month)

Lab	Frequency	Or Dose #
BMP		
BUN/Creatinine		
CBC		
CBC-Diff		
CMP		
Other:		

Pre-Medications:

- ☐ Acetaminophen (Tylenol) 650 mg, PO, Once, Administer prior to infusion
- ☐ Diphenhydramine 25 mg IV Push, Once, Administer prior to infusion
- ☐ Diphenhydramine 25 mg, PO, Once, Administer prior to infusion
- ☐ Methylprednisolone (Solu-Medrol) 100 mg IV Push, Once, Administer 30 minutes prior to infusion

Northwestern Medicine®

Infusion Therapy Medication Administration

Order Processing: Fax Form: **CDH PTC: Fax (630) 933-2444** *Phone (630)933-6272* **Delnor OPIC: Fax (630)208-3467** *Phone (630)208-4446*		
Patient Name:	**DOB:**	**MRN** ***(if known)***
Height: cm	**Weight:** kg	
Allergies (list all with reactions):		

Nursing Orders

☐ Infusion Nurse to assess the patient's vascular access and initiate orders for line care per department policies and procedures.

Hypersensitivity/Anaphylaxis Reaction:

- ☑ Diphenhydramine (Benadryl) 25 mg IV Push PRN Hypersensitivity Reaction or itching. May repeat X 1 if symptoms persist after 30 minutes.
- ☑ Epinephrine (Adrenaline) 0.3 mg Sub-Q Once PRN Anaphylaxis or Severe Bronchospasm.
- ☑ Hydrocortisone sodium succinate PF (Solu-Cortef) 100 mg IV Push Once PRN Hypersensitivity Reaction, Itching, rash, hives and/or shortness of breath.
- ☑ Oxygen: 2-3 L/min for Hypersensitivity and/or Anaphylaxis reaction.
- ☑ Notify Provider of hypersensitivity/anaphylactic reaction.
- ☑ Sodium Chloride 0.9% IV Bolus 250 mL over 15 minutes Once PRN Hypersensitivity and/or Anaphylaxis reaction.

Provider Name: _____Signature:_____

Date: _____ Time: _____