vitalcare of SAN ANGELO

11 W. Beauregard Ave. San Angelo, TX 76903
P / 325-777-1423 · F / 325-777-1430
www.vitalcaresanangelo.com

***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) ☐ **Midline:** _____lumen | ☐ **Peripheral IV** ☐ **PICC:** _____ lumen | ☐ **Port:** Needle size _____ Accessed_____ ☐ **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<br>• **Allergic response** - As per provider order: Diphenhydramine 50 mg slow IV push over 2-3 minutes<br>• **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<br>☐ **Patient education** on administration of IV therapy performed during skilled nursing visit<br>☐ **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<br>☐ **Subcutaneous port re-access** every 7 days and as needed at home or clinic<br>☐ **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)<br>☐ CBC ☐ BMP ☐ BUN ☐ CPK ☐ CRP ☐ ESR<br>☐ CBC w/diff ☐ CMP ☐ Creatinine ☐ Other: _____<br>☐ _____ trough, via peripheral venipuncture, prior to _____ dose then weekly<br>**Fax lab results to:** ☐ Vital Care of Meridian ☐ Providers office |
|---|---|---|---|

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

☐ **DISPENSE AS WRITTEN**

**PROVIDER SIGNATURE** **DATE/TIME**

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Name: _____ Date of Birth: _____ Date: _____

**PICC Line placement for long-term antibiotics**

**Dx:**

_____ _____

Dispense as written Substitution Permitted