PRGORD Progress & Order

PeaceHealth

Peace Harbor Medical Center
Outpatient Infusion Service Request

Phone: (541) 902-6019 Fax: (541) 902-1649

Thank you for selecting our infusion services team to care for your patient. Please provide ALL information listed below to ensure that we can process orders and schedule your patient for treatment without delay.

Part A- Patient scheduling and contact information:

Patient Name (Last, First): _____Date of Birth: _____

Patient Contact Information and Phone Number(s): _____

Ordering Provider Name (Print): _____

Provider Clinic or Service Address: _____

Clinic or Service Phone Number: _____ Clinic or Service Fax Number: _____

Diagnosis (include ICD 10 codes): _____

Medication and Service Requested - list J-Code/CPT code if known: _____

Date Service is Requested to Begin: _____ **Date Service is Expected to End**: _____

Order will expire 1 year from date of provider signature unless "date service is expected to end" is earlier.

Part B- Insurance and Prior Authorization. Any non-PeaceHealth provider must obtain prior authorization prior to service. *Attach a copy of authorization documentation received from insurance payer when submitting orders.*

Insurance (Payer) Company: _____

Prior Authorization Number and Conditions: _____

Prior Authorization Expiration Date: _____

Insurance (Payer) Contact Phone Number: _____

Part C- Elements needed to guide medication therapy are included with request for service:

☐ Orders and instruction (use the PeaceHealth approved ordering form if you are not a PeaceHealth provider) are complete and include provider signature at the bottom of each page. Check the boxes of ALL orders you would like to activate.

☐ For blood products, PeaceHealth Blood and Transfusion Consent form is signed and dated by the provider and the patient.

If information is located outside of PeaceHealth's electronic medical record system attach the following:

☐ A list of current medications reconciled by patient provider is available and includes a list of known allergies.

☐ Recent progress notes from ordering provider.

☐ A copy of relevant laboratory results and other appropriate supporting documentation.

IMPORTANT MESSAGE TO PROVIDERS: To reduce delays in treatment and added phone calls, you may participate to utilize PeaceHealth preferred medication formulary options by signing this document. A clinical pharmacist will adjust orders to align with PeaceHealth medical staff approved medication formulary options, policies, and procedures.

I agree to utilize PeaceHealth preferred medication formulary options, policies and procedures that have been authorized by PeaceHealth Medical Staff. This agreement will be issued for the duration of active orders contained within this treatment plan.

PROVIDER SIGNATURE: _____ DATE: _____ TIME:_____

FAX completed service request and orders to: PHMC OP Infusion and Nursing Services 541-902-1649

Patient Identification Label

PeaceHealth
Peace Harbor Medical Center

Iron Dextran (Infed)
Outpatient Infusion Therapy Plan

All Pre-Selected Boxed Orders Are Initiated by Default Unless Crossed Out by Practitioner. All Boxed Orders Require Practitioner Check to be Initiated.

Heading	Content
Pre-Medications	☐ **MethylPREDNISolone sodium succinate (Solu-MEDROL**) injection 125 mg IV once as needed prior to infusion if patient has greater than 1 documented anaphylactic drug allergy, severe asthma, and/or previous reaction to IV iron
Supportive Care	☐ **Iron dextran (Infed)** 1000 mg IV once infused over **1 hour** ☐ **Iron dextran (Infed)** 1000 mg IV once infused over **4 hours** ☒ Sodium chloride 0.9% (NS) continuous infusion at 100 mL/hour IV as needed for IV site discomfort. Run concurrent with IV iron infusion as needed. **Additional order instruction:** ☒ Administer the first 25 mg over 15 minutes (50 ml/hr) with nurse to stay with patient to monitor for infusion reactions. If no reaction is observed in the first 15 minutes, administer the remaining medication over 1-4 hours. Patient should be monitored for 30 minutes following completion of the infusion.
Nursing Orders	☒ Vital signs – prior to initiation of infusion, 15 minutes after initiation, and at end of infusion. ☒ Nurse to stay at bedside during first 15 minutes to monitor for hypersensitivity reactions. Patient should be monitored for 30 minutes following completion of the infusion. ☒ Monitor patient for MILD hypersensitivity reactions and initiate intervention as indicated: Mild hypersensitivity symptoms: metallic taste, chest tightening, back tightening, increased anxiety, flushing (normothermic), dizziness, nausea, headache, diaphoresis (normothermic), palpitations, fishbane reaction (transient flushing, chest and back tightening, joint pain) Step 1: STOP infusion, monitor vital signs and O2 every 5 minutes (until symptoms resolve or for a minimum of 15 minutes) Step 2: Administer methylprednisolone as ordered Step 3: Resume infusion at reduced rate of 50% original rate Step 4: Observe for 1 hour following infusion completion Step 5: Notify provider of adverse reaction ☒ Monitor patient for MODERATE hypersensitivity reactions and initiate intervention as indicated: Moderate hypersensitivity symptoms: mild symptoms PLUS chest discomfort (pressure), shortness of breath, hypo/hypertension (≥ 20-point change in SBP), increased temperature (≥ 38 C or 100.4 F) with rigors, urticaria, new onset or progressive edema Monitor for ANAPHYLAXIS: mild and moderate symptoms PLUS hypo/hypertension (≥ 40-point change in SBP), shortness of breath (RR > 20, O2 Sat < 90%) with wheezing or stridor, swelling of face/tongue, corneal edema, or periorbital edema Step 1: STOP infusion and activate rapid response Step 2: Monitor vital signs and O2 Sat every 5 minutes, place patient in left lateral tilt (if pregnant) Step 3: Administer methylprednisolone as ordered Step 4: Administer famotidine as ordered Step 5: Administer epinephrine as ordered (ONLY FOR ANAPHYLAXIS) Step 6: Transfer patient to main Emergency Department as soon as possible ☒ Notify provider if patient experiences SEVERE hypersensitivity reaction: sudden onset hypotension, tachycardia, dizziness, and/or shortness of breath/wheezing.

Practitioner Signature: _____Date of Order: _____Time: _____

Final page of orders must include signature of the ordering practitioner, date, and time.

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Nursing IV Access and Maintenance	**Select the most appropriate option below:** ☒ **Insert PERIPHERAL IV** as needed ☒ Sodium chloride 0.9% (NS) flush 10 mL IV once as needed for line care ☐ **Access and use NON-PICC Central Line/CVAD** as needed and confirm patency ☒ Initiate Central Line (Non-PICC) maintenance protocol ☒ Sodium chloride 0.9% (NS) injection 10 mL IV as needed for line care before and after medication administration, at discharge, and at de-access ☒ Sodium chloride 0.9% (NS) injection 20 mL IV once as needed for line care post lab draw ☒ Heparin, porcine (PF) 100 unit/mL flush 5 mL IV as needed for line care, for de-access ☒ Alteplase (Cathflo) injection 2 mg intra-catheter as needed for clearing central line catheter. Reconstitute with 2.2 mL sterile water for injection to the vial; let the vial stand undisturbed to allow large bubbles to dissipate. Mix by gently swirling until completely dissolved (complete dissolution should occur within 3 minutes); do not shake. Final concentration: 1 mg/mL. Instill medication in non-functional lumen. Do not use lumen while dwelling. Allow to dwell 30 minutes and check for patency by drawing back on lumen for blood return. If line is still not patent, allow medication to dwell an additional 90 minutes. Dwell time not to exceed 120 minutes. Use second dose of Alteplase (Cathflo) if catheter not patent after 120 minutes. If the catheter is functional, aspirate and waste the medication and residual clot prior to flushing line. ☐ **Access and use PICC Central Line/CVAD** as needed and confirm patency ☒ Initiate PICC maintenance protocol ☒ Change PICC line dressing weekly and as needed ☒ Sodium chloride 0.9% (NS) injection 10 mL IV as needed for line care before and after medication administration, at discharge, and at de-access ☒ Sodium chloride 0.9% (NS) injection 20 mL IV once as needed for line care post lab draw ☒ Alteplase (Cathflo) injection 2 mg intra-catheter as needed for clearing central line catheter
PRN Medications	☒ **Ondansetron (Zofran)** injection 8 mg IV once as needed for nausea, vomiting
Emergency Medications	**If patient has symptoms of anaphylaxis (wheezing, dyspnea, hypotension, angioedema, chest pain, or tongue swelling), discontinue infusion and initiate standard emergency response procedures.** ☒ **MethylPREDNISolone (Solu-Medrol)** injection 125 mg IV once as needed for mild, moderate or severe reaction (ONLY if not given as a pre-medication) ☒ **Famotidine (Pepcid)** injection 20 mg IV once as needed for severe allergic reaction ☒ **EPINEPHrine (Adrenalin)** injection 0.5 mg IM once as needed for severe drug reaction (flushing, dizziness, headache, diaphoresis, fever, palpitations, chest discomfort plus blood pressure changes (≥ 40 points in SBP), shortness of breath with wheezing and O2 Sat < 90%, and notify provider
Referral	☒ Ambulatory referral to OP Infusion Services
PHMC Outpatient Infusion Contact Information	**PROVIDER – PLEASE SIGN, DATE AND TIME ORDERS AND RETURN TO:** **PeaceHealth Peace Harbor Medical Center Outpatient Infusion Services Department** 400 Ninth Street, Florence, OR 97439 Contact Phone: 541-902-6019 and FAX ***541-902-1649***
Authorization by Verbal or Telephone Order	Person giving verbal or telephone order: _____ Person receiving verbal or telephone order: _____ ☐ Check to indicate verbal or telephone orders have been read back to confirm accuracy

Practitioner Signature: _____Date of Order: _____Time: _____

Final page of orders must include signature of the ordering practitioner, date, and time.