Home Infusion Pharmacy Prescriber Standing Order Form								
Pharmacy Name:	Address:					Ph:		
Prescriber/Practice Group/Health System Name:								
Address:								
Phone: City, State:			Zip:					
Prescription								
By signing below, I authorize the use of the flush medications and associated directions on my/our patients as applicable to the								
type of access device being utilized. This order will be valid for 1 year from the date it is signed.								
Utilization of Standing Order When utilized, please indicate patient's name and date implemented. A scanned copy of this document will be placed in the patient's electronic medical record.								
Patient Name:		Date Implemented:						
Ancillary Orders								
IV Flush Orders								
Access Device	0.9% NaCl	Flush			Heparin			
Peripheral IV	□ 2-3 mL p	re/post infusion			□ N/A			
	☐ 2-3 mL e	every 12 hours for n	naintenance	ntenance		☐ 1-3 mL heparin (10 units/mL) every 24 hours for maintenance		
Peripheral- Midline	☐ 3-5 mL p	ore/post infusion, 5	mL pre-lab d	raw, 10	☐ 3 mL heparin (10 units/mL) post-use or every 12 hours if not used			
	IIIL post-iai	Guraw			☐ 3 mL heparin (10 units/mL) post-use or 3 mL heparin (100 units/mL) every 24 hours for maintenance			
PICC & Central Tunneled & Non- tunneled	☐ 5 mL pre/post infusion, 5 m post-lab draw		ıL pre-lab draw, 10 mL		☐ 5 ml (heparin 10 units/ml) post use or every 24 hours if not used			
					☐ 3 ml (heparin 100 units/ml) post use or every 24 hours if not used			
Implanted Port	☐ 5 - 10 ml pre/post infusion, 1 lab draw			, .	☐ 3 - 5 ml (heparin 100 units/ml) post-use or every 24 hours if accessed but not used			
impanted Fort			LU - 20 ml pre/ post		☐ 3 - 5 ml (heparin 100 units/ml) flush weekly to monthly if not accessed.			
Valved Catheters: Chest, PICC, Midline		pre/post use, 10 - 2 itenance 5 - 10 ml a					N/A	
Catheter Occlusion								
☐ Cathflo Activase Instill into occluded catheter. Let dwell for 30 minutes before attempting to aspirate. Total dwell								
☐ 1 mg (midlines or patients <30 kg) time not to exceed 120 minutes.								
☐ 2 mg ☐ May repeat x 1 dose.								
Anaphylaxis Orders								
Does this patient require an anaphylaxis kit?								
☐ Yes, with 1st dose ☐ Yes, with all doses								
 Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ or IM x 1; repeat x 1 in 5 to 15 min PRN. Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg – 25mg max dose) IV or IM; repeat x 1 in 15 min PRN no 								
improvement. ■ 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.								
□ SUBQ Doses: Epinephrine Auto-Injector 0.3 mg 2-Pack Kit — Inject 0.3 mg IM x 1 dose PRN anaphylactic reaction, repeat x 1 PRN.								
The need to utilize the kit and protocol will be based on patient need.								
Nursing Orders: Skilled nurse to assess and administer and/or teach self-administration where appropriate via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.								
Prescriber Signature: Date:								
Authorizing Prescriber Name:		Phone:	Phone: Fax:					
Address:		NPI:						
City, State: Zip: Office Contact:								
CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that do not require authorization. You are obligated to maintain								

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