Florida Health Care Plans
An Independent Licensee of the Blue Cross and Blue Shield Association

FLORIDA HEALTH CARE PLANS
INFUSION THERAPY PHYSICIAN ORDERS

Date: _____ **MRN:** _____

1. Patient Name: _____ DOB: _____
SS#: _____ Phone #: _____ Diagnosis: _____
Dx Code: _____
Address: _____ City: _____ State: _____ Zip: _____
Allergies: _____ Weight: _____ Height: _____

2. Administer Medications as follows:

a. _____ **, IV q** _____ **hrs; times** _____
b. _____ **, IV q** _____ **hrs; times** _____
c. _____ **, IM q** _____ **hrs; times** _____
d. _____ **, SQq** _____ **hrs; times** _____

3. Venous Access:

☐ Peripheral ☐ Hickman ☐ Infusaport ☐ Groshong
☐ Mid line Catheter ☐ PICC line

4. Routine flush: ☐ with each dose, ☐ q day, ☐ q week, ☐ q month
as follows _____ cc's NSS, Drug,_____ cc's NSS, then _____ cc's of _____ Units of Heparin

5. Lab Request: _____

6. Consult FHCP Pharmacist in dosing medication according to lab results. Yes ☐ No☐

7. ANAPHLACTIC PROTOCOL:

A. If reaction occurs: STOP IV administration of medication immediately. Start 2nd IV 14 – 16 gauge. Start IV – NSS wide open.
B. Administer Epinephrine 1:1000/SQ. as follows:
1. Adults (over 12 years) -0.3ml q 10 min. x 2.
2. 6-12 years -0.2 ml q 10 min x 2.
3. 2-6 years – 0.15 ml q 10 min. x 2.
4. Infant – 2 years _____ (0.05 ml – 0.1 ml) q 10 min. x 2
C. Call 911 and notify MD.
D. Administer 0^2 via N/C if Resp <12 or signs of airway obstruction

8. ALLERGIC REACTION PROTOCOL:

A. If reaction occurs: Stop IV administration and KVO with 50 ml NSS.
B. Administer Benadryl:
1. Adults (over 12 years) – 50 mg IM or IV push.
2. 6-12 years – 1-2 mg/kg IM or IV push.
3. Under 6 years, Benadryl 1-2 mg/kg IM or IV push up to 50mg.
C. Notify MD of Reaction.
D. 0^2 PRN

Dr. Signature: _____ Date: _____ Phone: _____ Fax: _____
T.O. Dr.: _____ Date: _____ Time: _____
Nurse Signature: _____ Date: _____ Time: _____

If no time frame is specified, order must be renewed yearly or at stop order date whichever come first.