



NEVADA
INFUSION

Nevada Infusion

Reno Location - 5401 Longley Lane, Suite 34, Reno, NV 89511

Carson Location - 180 E. Winnie Lane, Carson City, NV, 89706

PH: 775-453-0667 | Fax: 775-470-8478

Antibiotic Infusion Order Form

Patient Name: _____ DOB: _____

Phone: _____ Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Sex: _____ Height: _____ Weight: _____ Allergies: _____

DIAGNOSIS: _____ **ICD-10:** _____

ORDER DETAILS:

1. Medication: _____ Dose: _____ IV every _____ hours x _____ days

2. Medication: _____ Dose: _____ IV every _____ hours x _____ days

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

Nevada Infusion Hypersensitivity Reaction Order Set

Other: _____

PUMP: IV Push or Elastomeric Device

NURSING: Provided by Nevada Infusion or Home Health

ACCESS: PICC, Midline, PORT, Peripheral IV, or Other: _____ (Specify if applicable)

FLUSHING Policy:

- PICC/Midline: Flush with 10 mL normal saline (NS) before and after each dose.
- PORT: Flush with 10 mL NS before and after each dose, followed by 5 mL Heparin (100 units/mL).
- Peripheral IV: Flush per standard protocol with normal saline before and after use.
- De-Clotting: May use Cathflo IV PRN for catheter occlusion as needed.

Dressing: PICC, Midline, PORT changed weekly or PRN

*****REMOVE PICC LINE AT THE END OF THERAPY*****

WEEKLY LABS: _____ Fax results: 775-470-8478 & _____

Draw labs peripherally if unable to draw from PICC/Midline

Provider Following after patient discharge: _____

PROVIDER INFORMATION:

Physician Name: _____ NPI: _____

Physician Signature: _____ Date: _____

Point of Contact: _____ Phone: _____ Email: _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **