Outpatient Miscellaneous Medication Order Set

Klickitat Valley Health
Phone: 509-772-2695 Fax: 509-773-3354

General

Patient Name _____ DOB _____ Height _____ Weight _____ Phone #_____

Order Start Date _____ Order Expiration Date *(max one year)* _____

Allergies: _____

Guidelines for Ordering:

1. Send **FACE SHEET** and **H&P** or most recent chart note.

DIAGNOSIS CODE: **Must include ICD10 code**

☐ Other: _____

Labs:

☐ _____

Nursing Orders

IV ACCESS: ☐ Place peripheral IV ☐ Access Implanted Port

If nurse to access implanted port please complete Port Access Order Set as well

☒ Vital Signs: baseline and every ___ minutes until discharge. Hold patient for ___ minutes post-medication administration to observe/monitor for adverse reaction

☐ Other: _____

Medication Orders **Must include medication name, dose, route, frequency, and PRN reason if applicable.

_____

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IF ANAPHYLACTIC REACTION OCCURS

☒ Stop infusion (if applicable), notify provider and/or Hospitalist on duty if afterhours, administer oxygen prn, administer Benadryl 50 mg IV or IM once STAT, administer Epinephrine (1:1000) 0.5mg IM once STAT, possible admission to emergency department for further evaluation/treatment.

Patient Name:
DOB:

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Ordering Facility/Provider Information

By signing below, I affirm the following:

I am responsible for the care of the patent identified on this form.

I hold an active, unrestricted license to practice medicine in _____ *(specify state)*

My physician license number is # _____ and I am acting within my scope of practice and authorized by law to order administration of the medication described above for the patient identified on this form.

Provider Signature: _____ **Date _____**

Printed name: _____ **Phone: _____** **Fax: _____**

KVH Provider Co-signature:

**Required for all external orders*

Provider Signature: _____ **Date _____**

Printed name: _____

Patient Name:
DOB: