Southwestern Vermont Medical Center | 100 Hospital Drive | Bennington, VT 05201

**OUTPATIENT PROVIDER ORDERS: Non-Hospitalized Treatment Infusion Order**

**ANTIBIOTICS**

# COMPLETE AND FAX ORDER TO (802) 440-8205

**For non SVMC Practices, provide and fax the following:**

- ☑ Clinical visit note
- ☑ Patient demographics, including insurance information
- ☑ Diagnostic lab

| FORM MUST BE COMPLETE AND SIGNED BY THE PROVIDER | |
|---|---|
| Patient Name: | Phone: |
| DOB: | Weight (kg): |
| Diagnosis: | Allergies: |
| Admit Status: Medical Ambulatory Care | |

Start Date: Stop Date:

| Antibiotics | Drug | Dose | Route | Frequency | # doses |
|---|---|---|---|---|---|
| ☐ | Cubicin (daptomycin) | _____milligrams mg/kg dosing | IV | Every ____ | |
| ☐ | Dalvance (dalbavancin) | _____milligrams | IV | Every 1 week | |
| ☐ | Invance (ertapenem) | _____milligrams | IV | Every 24 hours | |
| ☐ | Rocephin (ceftriaxone) | _____grams | IV | Every 24 hrs | |
| ☐ | | | | | |

| | Contingency Medications (PRN) |
|---|---|
| ☐ | acetaminophen (Tylenol) 1,000 milligram orally as needed x 1 dose for fever |
| ☐ | diphenhydrAMINE (Benadryl) 25 milligram orally as needed for signs and symptoms of allergic reaction |
| ☐ | loratadine (Claritin) 10 milligram orally as needed x1 dose for signs of allergic reaction |
| ☐ | solumedrol _____ milligram intravenously as needed x1 dose for signs of allergic reaction |
| ☑ | Cathflo [Alteplase] 1 ML intravenously as needed instill one dose for restoration of central venous access device, may repeat x1 after 2 hours. |
| ☐ | |

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| | IV Bolus Fluids |
|---|---|
| ☐ | Normal Saline 250 ml bolus at 999 ml/hr prn for hypotension (SBP less than or equal to 95 mmHg or symptomatic) |

**MONITORING**

- ☑ Access Port-a-cath or PICC if applicable.
- ☑ Insert peripheral line if needed.
- ☑ Flush central lines with saline per protocol
- ☑ Obtain vital signs prior to administration
- ☑ Monitor vital signs per delivery of care policy for medical ambulatory and infusion services.
- ☐ If signs and symptoms of a clinically significant hypersensitivity reaction or anaphylaxis occur, immediately discontinue administration and initiate appropriate medications and/or supportive therapy per protocol.
- ☐ Discontinue midline or PICC after last infusion

**Additional Orders**

| | |
|---|---|
| ☐ Diet Regular as tolerated | ☐ Other: _____ |
| ☐ Code status Full Code | ☐ Other: _____ |
| ☐ Activity as tolerated | ☐ Other: _____ |

☐ Discharge to home after medication administration with appropriate discharge instructions.

Provider Signature: _____ Date: _____ Time: _____

Printed Name: _____

**Provider Fax:** _____ **Provider Telephone:** _____

**Number of Pages:** _____ **Provider Email:** _____

**Comments:** _____

Dartmouth Health | Southwestern Vermont Medical Center

Patient Name: _____ DOB: _____

Insurance(s): _____ Date Order Initiated _____

| **Infusion Order Checklist** | | | | | **Office Check Date & Initials** | **MIC Check Date & Initials** |
|---|---|---|---|---|---|---|
| *CPT Code* | | | ***Medication supply*** | | | |
| *Diagnosis Code* | | | ☐ Buy & Bill | | | |
| *Medication Name* | | | ☐ Patient Supplied | | | |
| | | | | | | |
| ***Authorization Required?*** | *Primary Authorization* | | # | | | |
| ☐ Yes | *Secondary Authorization* | | # | | | |
| ☐ No | *Insurance Ref* | | # | | | |
| | *Medical Necessity passed? (Medicare only)* | | ☐ Yes ☐ No | | | |
| | | | | | | |
| ***Authorized Order Details*** | | | ***Appointment Dates*** | | | |
| Start /End Date: | | | | | | |
| Medication Dose | | | | | | |
| # Doses | | | | | | |
| # Visits | | | | | | |
| Infusion frequency | Weeks / months | | | | | |
| | | | | | | |
| ***Active Staff Provider?*** | ☐ Yes | | | | | |
| | ☐ No | | | | | |
| | ☐ N/A | | | | | |

****No Booking Reservation until Checklist is complete.**

**FAX this sheet with Order, Prior Authorization, and other required documents****

Office Staff Initials/Name: _____ Date: _____

MIC Staff Initials/Name: _____ Date: _____

**DAY OF PROCEDURE**

**Insurance Eligibility Check Scheduled Insurance is the Same: Staff Initials:_____**

**Eligibility Check through OneSource: Staff Initials: _____**

Dartmouth Health

Southwestern Vermont Medical Center
Medical Infusion Center
100 Hospital Drive | Bennington, VT 05201
Phone: 802-447-5506 | Fax: 802-440-8205

# FAX COVER LETTER

**The accompanying information is intended for the individual(s) identified below. If you have received this information in error, please immediately notify the sender by telephone to arrange for the return of the documents.**

| | |
|---|---|
| **TO:** | **DATE:** |
| **FROM: MEDICAL INFUSION CENTER** | **PHONE: 802-447-5506 FAX: 802-440-8205** |
| **PATIENT:** | **DOB:** |

SURGERY TYPE: _____ SURGERY DATE:: _____

surgeon: _____ anesthesia eval date: _____

# of pages(including cover) _____

☐ FOR REVIEW ☐ Please Reply ☐ Please FAX

## INFUSION COMMENTS:

**SVMC medical staff membership is no longer required to order infusions @ SVMC. That said, we require the following be completed by ordering office to coordinate patient:**

- Prior authorization completion
- Infusion order (Copy provided)- good for 6 months-and most recent office note with med list
- Patient scheduling (patients are NOT allowed to book themselves) Scheduling # 802-447-5542
- If establishing a new patient, scheduling will contact office to book once forms are verified.
- Fax all forms to MIC unit, fax #802-440-8205
- Send contact information for provider