Klickitat Valley Health

Outpatient Miscellaneous Medication Order Set

Phone: 509-772-2695 Fax: 509-773-3354

General

Patient Name ___________________ DOB ___________ Height _____ Weight ______ Phone #___________

Order Start Date _______________________________ Order Expiration Date _________________________

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

OUTPATIENT NURSE- PLACE STICKER HERE

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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: ______________________

OUTPATIENT NURSE- PLACE STICKER HERE