Print Patient Name (Required)

DOB

Height (cm): ____________________
Weight (kg): ____________________
BSA (m2): ____________________
Allergies: ______________________

Place Patient Barcode Here

Pentamidine Infusion

Admit to:	Diagnosis:	Infusion Date:
☐ Port ☐ Broviac ☐ PICC ☐ Place Peripheral IV ☑ Topical anesthetic per protocol ☑ Normal Saline/Heparin Flush per protocol		

Premedications

☐ Acetaminophen = _______ mg PO (max dose 1000 mg)
☐ Diphenhydramine = _______ mg IV or PO (max dose 50 mg)
☐ Other: ___________________________________

Pentamidine 4mg/kg ______ (max 300mg) mg IV in 5% Dextrose over 1-2 hours

Nursing Orders

Weigh patient prior to infusion.
Monitor Vital Signs at the beginning and the end of the infusion.
Obtain the following labs with IV or central line access prior to the start of infusion: ☐ CBC ☐ CMP ☐ BMP ☐ ALT ☐ AST ☐ UA ☐ IGG ☐ IGG/IGA/IGM ☐ Other: ________________ ☐ Call lab results prior to starting infusion ***Fax all lab results to ordering provider***
☐ Discharge once infusion completed ☐ Discharge 30 minutes post infusion

PRN medications:

☐ Ibuprofen (10 mg/kg) = _______ mg (Max 800 mg) PO once prn mild pain/temp > 100.4 (call for fever prior to giving)

☐ Acetaminophen (15 mg/kg) = ______mg (max 650 mg) PO once prn mild pain/temp > 100.4 (call for fever prior to giving, must wait at least 4 hrs from any prior dose)

Medications for allergic reaction (hives/itching/flushing, etc):

If allergic reaction occurs, call ordering provider immediately and give all medications ordered below. Do not delay administering medications on provider response. If ordering provider does not respond in 15 minutes call a Code Blue.

☐ Diphenhydramine (1mg/kg) = ______ mg (Max 50 mg) IV or PO once (must wait at least 4 hrs from any prior dose)

☐ Famotidine (0.5 mg/kg) = ______ mg (max 20 mg) IV once

☐ Methylprednisolone (2 mg/kg) =_______ mg (max 60 mg) IV once (must wait 6 hours from any prior steroid dose)

For Anaphylaxis (Call a Code Blue):

☐ < 10 kg: Epinephrine 1 mg/mL (0.01 mg/kg) = _______ mg IM once

☐ 10 to < 25 kg: Epinephrine 0.15 mg auto-injector (EpiPen Jr.) IM once

☐ ≥ 25 kg: Epinephrine 0.3 mg auto-injector (EpiPen) IM once

Orders good until this date: ______________ Infusion Frequency: ________________________

Provider's Signature: _______________________________________ Date: __________ Time: _________

Printed Name: _______________________________________