Nevada Infusion
Infusion Location (Pick one):
◯ **Reno** | ◯ **Sparks** | ◯ **Carson City** | ◯ **Las Vegas**
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 Agency (please list:)_____
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. **

Revised: 11/2026