McLeod Health

Place Sticker Here

Ceftriaxone (Rocephin) Treatment Plan

Patient Name: _____ DOB: _____

Height (cm): _____ Weight (kg): _____ Allergies: _____

Diagnosis (select one ICD-10 code):

☐ L08.9 Local infection of the skin and subcutaneous tissue, unspecified ☐ R78.81 Bacteremia

☐ M86.10 Other acute osteomyelitis, unspecified site ☐ M86.60 Other chronic osteomyelitis, unspecified site

☐ Other ICD 10 Code: _____ Diagnosis Description: _____

Drug Orders: The physician will select appropriate dosing based on indication

- Heparin and NS or D5W flushes as needed to maintain line
- Related items and/or supplies needed to administer medication and complete prescribed therapy
- Ceftriaxone (Rocephin) (J0696) per 100 mL NS IV to infuse over 30 minutes
- Dose: ☐ Ceftriaxone 1 gram Q24H
  ☐ Ceftriaxone 2 grams Q24H
  ☐ Other dose: _____
- Duration: ☐ 6 weeks (end date: _____)
  ☐ Other duration: _____ (end date: _____)

Lab Orders:

- Complete blood count (CBC) with differential weekly with reported results
- Basic metabolic panel (BMP) weekly with reported results
- C-reactive protein (CRP) weekly with reported results

☐ Other: _____

Standing Orders:

- Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.

Physician Signature: _____ **Date:** _____

Physician Name: _____ **Phone:** _____

Approved: 02/2022

Insurance/Authorization Information:

Insurance Type: _____

Insurance Authorization Reference Number: _____

Date Obtained: _____ Authorization Valid Until: _____

Additional Notes: _____

Fax completed Treatment Plan with authorization information to McLeod Infusion Services at the number below or call with any questions.

Clarendon: 803-435-3194 (Fax)

803-435-3226 (Phone)