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.

Dillon: 843-487-1491 (Fax)

843-487-1334 (Phone)