Referral for Community IV antibiotics – CELLULITIS PATHWAY

Patient Demographic Information

Patient Name: | Date of Birth: | POAC ☐ NON POAC ☐ Please select one

NHI Number: | Ph Number:

Address: | Cell Phone:

Initial visit ☐ Review visit ☐

ACC Number: | Date of Injury: | Date of Referral:

Verbal handover completed (essential)
Ph. (06) 350 8100 or 0800 001491

YES (circle)

Suitability for Home IV Management (all criteria must be met)

- ☐ Patient unlikely to deteriorate
- ☐ Patient's pain level under control and appropriate therapy commenced
- ☐ Patient's general health, especially cognitive capacity is suitable
- ☐ Patient's social circumstances are supportive of IV home therapy
- ☐ Patient has access to a telephone 24/7
- ☐ No safety issues for nursing staff or patient related to home IV therapy

Please contact the Infectious Diseases Physician if requiring guidance on antibiotic choice OR if the patient has a known allergy to penicillin or cephalosporin.

TREATMENT REQUEST

CrCl (ml/min) / eGFR	Cefazolin	Probenecid dose	Tick
>60	2 g every 24 hours	1 g daily	
40 to 60	2 g every 24 hours	No probenecid	
20 to 40	1 g every 24 hours	No probenecid	
<20	500 mg every 24 hours	No probenecid	

Request for District Nursing Service (DNS):

☐ IV Administration

Verbal acceptance obtained from DNS: YES (circle)

Date to commence: | Time of last dose given

Patient has IV antibiotic medication with them at home ☐ Yes ☐ No

Patient has been cannulated (avoid antecubital fossa AND attach extension set) ☐ Yes ☐ No

Please email the following with referral to DNS ASAP:

- ☐ Consultation Notes **(must include basic obs on EWS chart with variances)**
- ☐ Current medications, classifications, allergies/alerts
- ☐ Prescription – **IV** written and signed by GP

GP **Review** Date & Time:

GP Contact Details:

After Hours:

Email to:
districtnursingreferrals@midcentraldhb.govt.nz