Bailey-Boushay House
Virginia Mason

OUTPATIENT PROGRAM MEDICAL PROVIDER
HIV STATUS CERTIFICATION AND STANDING ORDERS

Client Name _____ DOB _____

Please initial below to certify client is HIV positive

_____ I hereby certify the above-named client has been diagnosed HIV-positive.
MD/ARNP/PA Initials

Attn: For PRN medications below, please check each box you wish to be available should the client need it:

For General Comfort:
- ☐ Acetaminophen 650 mg PO Q 4 Hours PRN
- ☐ Ibuprofen 400 mg PO Q6 Hours PRN. **Do not give if patient has a history of GI bleed**.
- ☐ Diphenhydramine 25 mg PO Q 4 Hours PRN
- ☐ Guaifenesin 5-10 mls PO Q 4 Hours PRN cough
- ☐ Earwax removal drops 6.5%. Instill 5-10 drops into affected ear twice daily PRN until resolved

For Gastric Complaints:
- ☐ *Maalox or *Mylanta 30 mls PO Q 2 Hours PRN *[separate from integrase regimens e.g. Biktarvy, Genvoya, Dolutegravir and raltegravir]
- ☐ Simethicone 80 mg PO Q 4 Hours PRN
- ☐ *Tums 1-2 tabs PO Q 1 Hour PRN *[separate from integrase regimens e.g. Biktarvy, Genvoya, Dolutegravir and raltegravir]

For Diarrhea:
- ☐ Imodium 4 mg after 1st loose stool, then 2 mg Q each loose stool PRN; Max 16 mg/24 Hours

For Constipation:
- ☐ *MOM 30 mls PO Q Day PRN constipation *[separate from integrase regimens e.g. Biktarvy, Genvoya, Dolutegravir and raltegravir]
- ☐ Senna 8.6 mg tab, 1-4 tabs QHS PRN

The following will be available to client, unless otherwise indicated:

☑ Client may receive prescribed regular dose and PRN medications while at BBH Outpatient. This includes meds that may have been mailed to client, filled at an outside pharmacy, and/or brought to BBH for assistance with managing.
☑ Physical Therapy evaluation ☑ Occupational Therapy evaluation ☑ Speech Therapy evaluation
☑ Central Line Care per VMFH policy
☑ PPD per BBH policy: Admitted clients may be evaluated for presence of active TB as needed. Bailey-Boushay House will provide a 2-step PPD, unless there is a documented history of TB or reactive PPD.
☑ May have Inactivated, Injectable Influenza Vaccine 0.5 ml IM yearly
☑ May have Inactivated, Injectable Hepatitis A Vaccine 2 dose series, unless there is documentation of prior vaccination or natural immunity
☑ May have Inactivated, Injectable COVID-19 Vaccine or Booster, if indicated
☑ May be tested as needed for COVID-19 via oral/nasal/nasopharyngeal swab

MD/ARNP/PA Printed Name: _____

DEA #: _____ NPI # : _____

MD/ARNP/PA Signature: _____ Date : _____