

**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 Initials

**Please check ALL boxes you wish to order:**

- Client may receive prescribed regular dose and PRN medications while at BBH-Outpatient. This includes meds client may have had filled at an outside pharmacy and has brought to BBH for assistance with managing.

**May have, if indicated:**

- Physical Therapy evaluation
- Speech Therapy evaluation
- Occupational Therapy evaluation
- Massage
- PPD per BBH policy: Admitted clients must be evaluated for presence of active TB as required by WAC 388-97-1400 / 1440. Bailey-Boushay House will provide a 2-step PPD, and will re-test annually, unless there is a documented history of a past positive result.
- May have Inactivated, Injectable Influenza Vaccine 0.5 ml IM yearly

**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 pH sensitive drugs such as: Atazanavir, Itraconazole]
- Simethicone 80 mg PO Q 4 Hours PRN
- \*Tums 1-2 tabs PO Q 1 Hour PRN \*[separate from pH sensitive drugs such as: Atazanavir, Itraconazole]

**For Diarrhea:**

- Imodium 4 mg after 1<sup>st</sup> 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 pH sensitive drugs such as: Atazanavir, Itraconazole]
- Senna 8.6 mg tab, 1-4 tabs QHS PRN

**For Central Line Care:**

- Per VMMC policy

MD/ARNP Printed Name: \_\_\_\_\_

DEA # : \_\_\_\_\_ NPI # : \_\_\_\_\_

MD/ARNP Signature: \_\_\_\_\_ Date : \_\_\_\_\_