

HOME INFUSION PHARMACY PRESCRIBER ORDER FORM

Pharmacy Name:	Address:	Ph:
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Prescriber/Practice Group/Health System Name:

Patient Name:	Date of Birth:
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Address:

Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:	<input type="checkbox"/> lbs <input type="checkbox"/> kg
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Clinical Information

Primary Diagnosis Description:	ICD-10 Code:
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Allergies:

Prescription

Please indicate medication, dose, frequency, route, and length of therapy:

Ancillary Orders

IV Flush Orders

Access Device	0.9% NaCl Flush	Heparin
Peripheral IV	<input type="checkbox"/> 2-3 mL pre/post infusion <input type="checkbox"/> 2-3 mL every 12 hours for maintenance	<input type="checkbox"/> N/A <input type="checkbox"/> 1-3 mL heparin (10 units/mL) every 24 hours for maintenance
Peripheral- Midline	<input type="checkbox"/> 3-5 mL pre/post infusion, 5 mL pre-lab draw, 10 mL post-lab draw	<input type="checkbox"/> 3 mL heparin (10 units/mL) post-use or every 12 hours if not used <input type="checkbox"/> 3 mL heparin (10 units/mL) post-use or 3 mL heparin (100 units/mL) every 24 hours for maintenance
PICC & Central Tunneled & Non-tunneled	<input type="checkbox"/> 5 mL pre/post infusion, 5 mL pre-lab draw, 10 mL post-lab draw	<input type="checkbox"/> 5 ml (heparin 10 units/ml) post use or every 24 hours if not used <input type="checkbox"/> 3 ml (heparin 100 units/ml) post use or every 24 hours if not used
Implanted Port	<input type="checkbox"/> 5 - 10 ml pre/post infusion, 10 - 20 ml pre/ post lab draw	<input type="checkbox"/> 3 - 5 ml (heparin 100 units/ml) post-use or every 24 hours if accessed but not used <input type="checkbox"/> 3 - 5 ml (heparin 100 units/ml) flush weekly to monthly if not accessed.
Valved Catheters: Chest, PICC, Midline	<input type="checkbox"/> 5 - 10 ml pre/post use, 10 - 20 ml pre/post lab draw; maintenance 5 - 10 ml at least weekly	N/A

Lab Orders

- No labs ordered at this time.
- Other: _____

Skilled nurse to assess and administer and/or teach self-administration where appropriate via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:	Phone:	Fax:
Address:	NPI:	
City, State:	Zip:	Office Contact:

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