UTAH - AMBULATORY INFUSION CENTER PRESCRIBER ORDER FORM

Infusion Center Location: ☐ American Fork ☐ Layton ☐ Murray ☐ St. George ☐ Toole

Prescriber/Practice Group/Health System Name:

Patient Name:	**Date of Birth:**
Address:	

Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**
Allergies:	

Prescription

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

Ancillary Orders

IV Flush Orders

☐ Peripheral:	0.9% Sodium Chloride 2 to 3 mL pre-/post-use. Heparin (10 unit/mL) 1 to 3 mL post-use.
☐ For Maintenance *(select one)*:	☐ 0.9% Sodium Chloride 2 to 3 mL every 12 hr ***or*** ☐ heparin (10 unit/mL) 1 to 3 mL every 24 hr.
☐ Peripheral-Midline:	0.9% Sodium Chloride 3 to 5 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw. Heparin (10 unit/mL) 3 mL post-use.
☐ For Maintenance *(select one)*:	Heparin ☐ (10 unit/mL) 3 mL every 12 hr ***or*** ☐ (100 unit/mL) 3 mL every 24 hr.
☐ PICC and Central Tunneled/Non-Tunneled: *(select one)*	0.9% Sodium Chloride 5 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw. Heparin ☐ (10 unit/mL) 5 mL ***or*** ☐ (100 unit/mL) post-use.
☐ For Maintenance *(select one)*:	Heparin ☐ (10 unit/mL) 5 mL ***or*** ☐ (100 unit/mL) 3 mL every 24 hr.
☐ Implanted Port:	0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.
☐ Valved Catheters:	0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. For maintenance, 0.9% Sodium Chloride 5 to 10 mL at least weekly.

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:**	

Please fax this completed form, along with a demographic sheet and most recent clinical note to 888-717-7578

