

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: 0.9% Sodium Chloride 5 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw.
(select one)
- 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

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