

Cert Period: _____ to _____

Home Infusion Post Acute Prescriber Order Form

To: Option Care Health		Phone:	Fax:	Date:																		
From:		Phone: X	Fax:	# Pages, Incl. Cover:																		
Patient Name:		Patient Phone:	DOB:	Gender:																		
Address:		City:	State:	Zip:																		
Medicare ID # (if applicable) _____ <input type="checkbox"/> Patient is homebound per Medicare criteria																						
Please attach the following: demographics; insurance information; H&P; medication profile																						
Diagnosis(es) or Problems Related to or Requiring the Need for Option Care Health Services																						
Clinical Background and Orders																						
1	Ht: _____ <input type="checkbox"/> In <input type="checkbox"/> cm Wt: _____ <input type="checkbox"/> lb <input type="checkbox"/> kg Date: _____ Code Status: _____ IV Access: _____ Allergies: <input type="checkbox"/> NKDA or (list): _____ <input type="checkbox"/> Advance Directives																					
2	Rehab Potential: <input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> Terminal <input type="checkbox"/> Palliative Care Mental Status: <input type="checkbox"/> Alert/Oriented <input type="checkbox"/> Confused <input type="checkbox"/> Depressed Safety Measures: <input type="checkbox"/> 911/EMS <input type="checkbox"/> Standard Precautions <input type="checkbox"/> Med Storage Hazard <input type="checkbox"/> Hazardous Waste <input type="checkbox"/> Electrical Emergency <input type="checkbox"/> Disaster Diet: <input type="checkbox"/> Regular <input type="checkbox"/> ADA <input type="checkbox"/> Cardiac <input type="checkbox"/> Other _____ Functional Limitations: _____ Prescription: Drug (Additional drugs listed on separate attachment, if necessary) Directions Prognosis <input type="checkbox"/> _____ GM IV Q _____ H X _____ Days <input type="checkbox"/> Excellent <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> _____ IV Q _____ H X _____ Days <input type="checkbox"/> Poor <input type="checkbox"/> Guarded <input type="checkbox"/> _____ IV Q _____ H X _____ Days Adverse Reaction Orders: <input type="checkbox"/> If first dose, check here and include Treatment Guidelines and Physicians Order for Adult Drug Related Adverse Reactions																					
3	Catheter Maintenance, Supply and Nursing Orders: <ul style="list-style-type: none"> • Option Care Health to provide IV catheter maintenance therapy for non-treatment days as needed. • Indicate appropriate flushing protocol by checking the appropriate item(s) • Provide all supplies necessary to administer therapy <input type="checkbox"/> Alteplase (Cathflo) 2mg per lumen to dwell, may dispense and repeat x 1 per incident of sluggish/occluded line. Qty: #2 <input type="checkbox"/> Skilled nurse to train patient/caregiver to self-administer medication, start peripheral line (where required), access/maintain central IV access (where applicable), monitor and treat ADRs, and administer medications as ordered. RN to discontinue venous access at completion of therapy. <input type="checkbox"/> RN to pull PICC line at end of therapy • SN Visit Frequency: _____ with _____ PRN Visits for: _____ • SN to assess with each patient visit: <ul style="list-style-type: none"> <input type="checkbox"/> Response to Therapy <input type="checkbox"/> Instruction Needs <input type="checkbox"/> Compliance <input type="checkbox"/> Home Safety <input type="checkbox"/> Pain Level <input type="checkbox"/> Physical Assessment <input type="checkbox"/> Virtual/In Person 	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center;">Indicated Access Device to be Utilized</th> <th style="text-align: center;">NS Flush (0.9% NaCl)</th> <th style="text-align: center;">Heparin</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><input type="checkbox"/> Peripheral</td> <td style="text-align: center;"><input type="checkbox"/> 2 - 3 ml pre/post use</td> <td style="text-align: center;"><input type="checkbox"/> 1 - 3 ml (heparin 10 units/ml) post-use or every 24 hrs if not used</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/> Peripheral-Midline</td> <td style="text-align: center;"><input type="checkbox"/> 3 - 5 ml pre/post use; 5 ml pre/10 ml post lab draw</td> <td style="text-align: center;"><input type="checkbox"/> 3 ml (heparin 10 units/ml) post-use or every 12 hours if not used <input type="checkbox"/> 3 ml (heparin 100 units/ml) post-use or every 24 hrs if not used</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/> PICC & Central Tunneled & Non-tunneled</td> <td style="text-align: center;"><input type="checkbox"/> 5 ml pre/post use; 5 ml pre/10 ml post lab draw</td> <td style="text-align: center;"><input type="checkbox"/> 3 ml (heparin 100 units/ml) post-use or every 24 hours if not used <input type="checkbox"/> 5 ml (heparin 10 units/ml) post-use or every 24 hours if not used</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/> Implanted Port</td> <td style="text-align: center;"><input type="checkbox"/> 5 - 10 ml pre/post infusion; 10 - 20 ml pre/post lab draw</td> <td style="text-align: center;"><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</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/> Valved Catheters: Chest, PICC, Midline</td> <td style="text-align: center;"><input type="checkbox"/> 5 - 10 ml pre/post use; 10 - 20 ml pre/post lab draw; maintenance 5 - 10 ml at least weekly</td> <td style="text-align: center;">N/A</td> </tr> </tbody> </table>	Indicated Access Device to be Utilized	NS Flush (0.9% NaCl)	Heparin	<input type="checkbox"/> Peripheral	<input type="checkbox"/> 2 - 3 ml pre/post use	<input type="checkbox"/> 1 - 3 ml (heparin 10 units/ml) post-use or every 24 hrs if not used	<input type="checkbox"/> Peripheral-Midline	<input type="checkbox"/> 3 - 5 ml pre/post use; 5 ml pre/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 100 units/ml) post-use or every 24 hrs if not used	<input type="checkbox"/> PICC & Central Tunneled & Non-tunneled	<input type="checkbox"/> 5 ml pre/post use; 5 ml pre/10 ml post lab draw	<input type="checkbox"/> 3 ml (heparin 100 units/ml) post-use or every 24 hours if not used <input type="checkbox"/> 5 ml (heparin 10 units/ml) post-use or every 24 hours if not used	<input type="checkbox"/> 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	<input type="checkbox"/> 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		
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4	Lab and Other Orders: <ul style="list-style-type: none"> <input type="checkbox"/> Discharge Plans: Discharge from home health services when goals are met and/or therapy completed. <input type="checkbox"/> Discharge to care of self / family / caregiver with MD follow-up 																					

5 Goals:

- Patient/Caregiver will demonstrate safe administration of Rx therapy. Will achieve Partial Complete independence in therapy as applicable.
- Patient/Caregiver will verbalize potential side effects and/or complications of therapy to report and appropriate action as required.
- Patient/Caregiver will demonstrate correct care and maintenance of access device: IV Enteral Subcutaneous Other: _____
- Infusion access device will remain free from infection or other complications. Resolve/Improve infection(s): _____
- Therapy will be tolerated without adverse event Patient will maintain/improve activity level Patient will demonstrate improved mobility.
- Nutritional status Fluid/electrolyte balance will be maintained/improved as evidenced by labs WNL, weight stabilization and/or improved clinical condition. Patient's HAE symptoms shall be adequately controlled with adverse reaction prevented or recognized and minimized.
- Patient's pain level, on a scale of 0 - 10, will be at an acceptable level to the patient of: _____
- Other: _____

I certify that the use of the indicated treatment is medically necessary.

Prescriber Signature: _____ **Date:** _____

Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Prescriber NPI: _____
Office Contact: _____
Direct Contact Number/Extension: _____

Fax completed form, insurance information, and clinical documentation to:

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