

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:																									
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	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:40%;">Catheter Maintenance, Supply and Nursing Orders:</th> <th style="width:15%;">Indicated Access Device to be Utilized</th> <th style="width:20%;">NS Flush (0.9% NaCl)</th> <th style="width:25%;">Heparin</th> </tr> </thead> <tbody> <tr> <td> <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. 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4	Lab and Other Orders: <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:
	<input type="checkbox"/> Patient/Caregiver will demonstrate safe administration of Rx therapy. Will achieve <input type="checkbox"/> Partial <input type="checkbox"/> Complete independence in therapy as applicable.
	<input type="checkbox"/> Patient/Caregiver will verbalize potential side effects and/or complications of therapy to report and appropriate action as required.
	<input type="checkbox"/> Patient/Caregiver will demonstrate correct care and maintenance of access device: <input type="checkbox"/> IV <input type="checkbox"/> Enteral <input type="checkbox"/> Subcutaneous <input type="checkbox"/> Other: _____
	<input type="checkbox"/> Infusion access device will remain free from infection or other complications. <input type="checkbox"/> Resolve/Improve infection(s): _____
	<input type="checkbox"/> Therapy will be tolerated without adverse event <input type="checkbox"/> Patient will maintain/improve activity level <input type="checkbox"/> Patient will demonstrate improved mobility.
	<input type="checkbox"/> Nutritional status <input type="checkbox"/> Fluid/electrolyte balance will be maintained/improved as evidenced by labs WNL, weight stabilization and/or improved clinical condition. <input type="checkbox"/> Patient's HAE symptoms shall be adequately controlled with adverse reaction prevented or recognized and minimized.
	<input type="checkbox"/> Patient's pain level, on a scale of 0 - 10, will be at an acceptable level to the patient of: _____
<input type="checkbox"/> Other: _____	

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

Prescriber Signature: _____ Date: _____

Prescriber Name: _____	Prescriber NPI: _____
Address: _____	Office Contact: _____
City: _____ State: _____ Zip: _____	Direct Contact Number/Extension: _____
Phone: _____ Fax: _____	

Fax Orders to:

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