AOM Infusion
*Improving Health, Enhancing Life*

Fax To: 800-528-9860
Phone: 800-746-9089
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## Patient Demographic Information

| | | | |
|---|---|---|---|
| **Last Name:** | | **First Name:** | |
| **Address:** | | **Apt #:** | |
| **City:** | | **State:** | **Zip:** |
| **Primary Phone:** | | **Work Phone:** | |
| **Height:** | **Weight:** | **Sex:** ☐ Male ☐ Female | **DOB:** |
| **Emergency Contact:** | | **Phone:** | |

## Insurance Information

| | |
|---|---|
| **Primary Insurance Provider:** | **Policy Number:** |
| **Phone Number:** | **Group:** |
| **Secondary Insurance Provider:** | **Policy Number:** |
| **Phone Number:** | **Group:** |
| **Employer Name:** | **Phone Number:** |

## Diagnosis/General Information

| | | |
|---|---|---|
| **Primary Diagnosis:** | **ICD Code:** | **Caregiver:** |
| **Additional Diagnosis:** | **ICD Code:** | **Caregiver Phone:** |
| **Hx of HTN:** | **Diabetes:** | **Allergies:** |

## Prescription Information (or attach a copy of the prescription)

**Infusion Therapy:**
Preferred Brand _____ OR ☐ Pharmacist will determine appropriate product based on clinical assessment, insurance requirements and availability)

**Dose:** *(please select option(s) and provide complete information, pharmacy to round to the nearest 5 gram vial)*

☐ Administration Rate = Follow Manufacturer's Guidelines
☐ Loading Dose: _____ gm/kg over _____ days, then ☐ Maintenance dose: _____ gm/kg over _____ days, every _____ weeks x _____ cycles
☐ Other Regimen_____

**Infusion Rate:** *(please select one and provide complete information)*
☐ Pharmacist to determine OR ☐ Start at _____ ml/hr, then increase by _____ ml/hr every _____ minutes to maximum

**Pre-Medication:**
Diphenhydramine, 25 mg capsule: 1-2 capsules by mouth 15-30 minutes before each infusion Decline
Acetaminophen, 650 mg tablet: 1-2 tablets by mouth 15-30 minutes before each infusion Decline

☐ Other _____ Strength _____ Directions: _____

**Vascular Access Device:** ☐ Peripheral Catheter ☐ PICC ☐ Port ☐ Other (describe # of lumens): _____

**Flush Orders:** (If IV ordered the following flush protocols will be followed):
☐ **Sodium Chloride 0.9%**
Peripheral Line: 3 ml before each dose and 3 ml after each dose and prn; Central Line: 5-10 ml before each dose and 5-10ml after each dose and prn
☐ **Heparin 10 u/ml** Peripheral Line: 3 ml after last sodium flush and prn
☐ **Heparin 100 u/ml** Central Line: 5 ml after last sodium flush and prn
Provide needles, syringes, VAD supplies & other ancillary supplies needed for infusion

**Hydration Orders: Infuse** _____ **mg** _____ **solution** ☐ **Prior to** ☐ **Following**

**Labs:** Results will be faxed to physician's office. If no frequency noted, ordered labs to be done prior to initial infusion only. Labs will not be drawn on weekend/holidays. Not appropriate for STAT labs.

☐ Quantitative IgA prior to first dispense. Pharmacist to obtain authorization from MD
☐ Other: _____ Frequency of Labs: _____

**Nursing Orders for Home Infusion Monitor (IV Only)** ☐
Observe: Vital signs prior to infusion. Blood pressure and pulse every 15 mins for 1st hour, then every 30 mins until stable infusion rate, then every hour.
Watch for: Signs of fluid overload, cardiovascular systems, allergic reactions. **Contact Physician:** For adverse events, stop the infusion. Can restart the infusion at the same or lower rate pending physician's approval or if symptoms subside.

## Physician Information

| | | | | | |
|---|---|---|---|---|---|
| **Prescribing Physician:** | | | **Office Contact Name:** | | |
| **Address:** | | | **City:** | **State:** | **Zip:** |
| **Phone:** | **Fax:** | **License #:** | **UPIN #:** | **NPI:** | |