AOM Infusion
Improving Health, Enhancing Life

Fax To: 800-528-9860
Phone: 800-746-9089
website: aominfusionrx.com

Patient Demographic Information

Last Name:		First Name:	
Address:		Apt #:	
City:		State:	Zip:
Primary Phone:		Alternate 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:
☐ Pharmacist will determine appropriate product based on clinical assessment, insurance requirements and availability
OR Preferred Brand _____

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
☐ Infuse: _____ gms over _____ hours x _____ days every _____ weeks/months x _____ months/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
☐ Acetaminophen, 325 mg tablet: 1-2 tablets by mouth 15-30 minutes before each infusion
☐ Other _____ Strength _____ Directions: _____
☐ None

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 units/ml** Peripheral Line: 3 ml after last sodium flush and prn
☐ **Heparin 100 units/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 _____ ml _____ 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: