

Patient Demographic Information

Last Name:		First Name:	
Address:		Apt #:	
City:	State:	Zip:	
Primary Phone:		Alternate Phone:	
Height:	Weight (kg):	Sex: <input type="checkbox"/> Male <input type="checkbox"/> 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: 3ml before each dose and 3ml after each dose and prn; Central Line: 5-10ml before each dose and 5-10ml after each dose and prn

 Heparin 10 units/ml Peripheral Line: 3ml after last sodium flush and prn

 Heparin 100 units/ml Central Line: 5ml 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/evenings. Not appropriate for STAT labs.

 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:	