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 (kg):	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: 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: