

Home Infusion Order Form

Phone: 508-624-8555

Fax: 508-302-6144



Patient Name: _____

Date: _____

Height: _____

Address: _____

Diagnosis: _____

Weight: _____

DOB: _____

Allergies: _____

** Indicates required field*

***MEDICATION ORDER:**

Drug	Route	Dose	Frequency	Length of Therapy
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

***LINE TYPE (select one)** PICC Midline Central line Port (Port Needle Size: _____)

***VENOUS ACCESS FLUSH ORDER**

Normal saline flush 5 – 10 ml

Flush catheter with 5 – 20 ml before and after each infusion / catheter blood draw or PRN catheter maintenance

Pharmacy to dispense quantity sufficient for one year from date above

***VENOUS ACCESS FLUSH ORDER (select one)**

Heparin 10 unit/ml 3 - 5 ml Heparin 100 unit/ml 3 - 5 ml No Heparin

Instill 3 - 5 ml before and after each infusion / catheter blood draw or PRN monthly catheter maintenance

Pharmacy to dispense quantity sufficient for one year from date above

OTHER ACCESS ORDERS (select any/all that apply)

Alteplase (Cathflo) 2mg per lumen to dwell, may dispense and repeat x1 per incident of sluggish/occluded line. Qty#2

RN to pull PICC line at end of therapy

***LAB ORDERS (Select all required):** Lab start date/frequency: _____

CBC with Diff BMP CMP CPK

ESR CRP Liver Panel BUN/Creat

Vancomycin trough (target trough level) _____ Frequency _____

Aminoglycoside trough peak (target levels) _____ Frequency _____

***Report lab results to/following physician:**

Name: _____ Phone: _____ Fax: _____

Prescriber name (printed): _____ Prescriber signature: _____ NPI: _____

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Interchange is mandated unless the prescriber indicates "no substitution" in accordance with the law: _____