Home Infusion Order Form
Phone: 508-624-8555
Fax: 508-302-6144

option care health™

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:_____

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