

**HOME INFUSION PHARMACY    PRESCRIBER ORDER FORM**

Pharmacy Name: \_\_\_\_\_ Address: \_\_\_\_\_ Ph: \_\_\_\_\_



Prescriber/Practice Group/Health System Name: \_\_\_\_\_  
Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Height: \_\_\_\_\_  inches  cm Weight: \_\_\_\_\_  lbs  kg

**Clinical Information**

Primary Diagnosis Description: \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_

Allergies: \_\_\_\_\_

**Prescription**

*Please indicate medication, dose, frequency, route, and length of therapy:*

\_\_\_\_\_

**Ancillary Orders**

**IV Flush Orders**

- Peripheral: NS 2 to 3 mL pre-/post-use. Heparin (10 unit/mL) 1 to 3 mL post-use.
- For Maintenance (select one):  NS 2 to 3 mL every 12 hr **or**  heparin (10 unit/mL) 1 to 3 mL every 24 hr.
- Peripheral-Midline: NS 3 to 5 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw. Heparin (10 unit/mL) 3 mL post-use.
- For Maintenance (select one): Heparin  (10 unit/mL) 3 mL every 12 hr **or**  (100 unit/mL) 3 mL every 24 hr.
- PICC and Central Tunneled/Non-Tunneled: NS 5 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw. Heparin  (10 unit/mL) 5 mL **or**  (100 unit/mL) post-use.
- For Maintenance (select one): Heparin  (10 unit/mL) 5 mL **or**  (100 unit/mL) 3 mL every 24 hr.
- Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.
- Valved Catheters: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. For maintenance, NS 5 to 10 mL at least weekly.

**Lab Orders**

- No labs ordered at this time.
- Other: \_\_\_\_\_

Skilled nurse to assess and administer and/or teach self-administration where appropriate via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

*I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.*

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Prescriber Information**

Prescriber Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Address: \_\_\_\_\_ NPI: \_\_\_\_\_  
City, State: \_\_\_\_\_ Zip: \_\_\_\_\_ Office Contact: \_\_\_\_\_

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