

Infusion Therapy Order Form



Prescriber's Name: _____ MD / DO / NP / PA
Address: _____
City _____ State _____ Zip _____
Office Contact: _____ Phone# _____ Fax# _____
NPI: _____ DEA: _____ License: _____

PATIENT INFORMATION

Send updates to Fax E-mail to _____ Text to Phone# _____

Patient's Name: _____ SS# _____ DOB: _____

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Work or Cell: _____ Emergency Contact: _____

Allergies: _____ Sex: M ___ F ___ Wt: _____ Ht: _____ Diabetic: Y N

Patient previously on treatment: Y N Date: _____

Primary Insurance: _____ Policy# _____

Insured: _____ Group _____

Phone: _____ BIN# _____ PCN# _____

* Please include current patient medication list with referral *

Vascular Access type PICC, please specify type _____ Port-a-cath, please specify type _____
(ex: Hickman, Groshong, Power PICC Solo, Power PICC)

Tunneler Catheter, please specify _____

Specify number of lumens _____



Medication name: _____

Strength / Dose _____

Directions for administration _____

SDHC Pharmacist to perform kinetic dosing to keep trough level between _____

Duration of Therapy or Stop Date _____



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Strength / Dose _____

Directions for administration _____

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Duration of Therapy or Stop Date _____

Sodium Chloride 0.9% flush 10 ml to each lumen of IV line per S.A.S.H. method, every 12 hours and as needed, #QS.
Refill as needed * dispense a quantity sufficient for duration of therapy.

Heparin (100 unit/ml) 3 ml to each lumen of IV line per S.A.S.H method, every 12 hours and as needed, #QS.
note: 5 ml heparin required for Power Port
(circle if desired) note: 10 unit/ml for pediatric patient
Refill as needed * dispense a quantity sufficient for duration of therapy.

EpiPen (Epinephrine) Auto-Injector 0.3mg IM as needed for severe allergic reaction, #QS.
(0.01 mg/kg for pediatrics)
Refill as needed * dispense a quantity sufficient for duration of therapy.

Cathflo (activase) 2 mg/2 ml to each lumen of IV line as needed for occlusion.
Instill 2 ml to each lumen of IV line and let dwell for 60-90 minutes. Aspirate
5-10 ml blood and waste. If no blood return may repeat x1, #QS.
Refill as needed * dispense a quantity sufficient for duration of therapy.

Prescriber Signature: _____ May Substitute _____ Dispense as Written _____ Date: _____