emerging HEALTH

Post-acute home infusion order form

Patient information

First name	Last name	Date of birth
Patient address		
City	State	ZIP
Phone	Height ☐ inches ☐ cm	Weight ☐ lbs ☐ kg
Case manager name	Prescriber responsible for orders and follow-up	

Clinical information

Diagnosis		ICD-10
Allergies		
Date of next provider visit	Expected start of care	Length of therapy in the home

Medication orders

Medication	Dose	Frequency	Route
Medication	Dose	Frequency	Route
Medication	Dose	Frequency	Route

IV Catheter and flushing

Catheter	Order	
☐ **PICC** #of Lumens: _____	Sodium Chloride 0.9% 10 mL prefilled syringe Flush each lumen with 10-20 mL normal saline before and after each use or every week when not in use.	*Refill PRN*
☐ **Midline**	Sodium Chloride 0.9% 10 mL prefilled syringe Flush each lumen with 10-20 mL normal saline before and after each use or every 12 hours when not in use.	*Refill PRN*
☐ **Tunneled CVC** #of Lumens: _____	Sodium Chloride 0.9% 10 mL prefilled syringe & Heparin 10 unit/mL 5 mL prefilled syringe Flush each lumen with 10-20 mL normal saline before and after each use flowed by _____ mL heparin 10 unit/mL after final normal saline flush, or daily when not in use.	*Refill PRN*
☐ **Implanted port** #of Lumens: _____	Sodium Chloride 0.9% 10 mL prefilled syringe & Heparin 100 unit/mL 5 mL prefilled syringe. Flush with 10-20 mL normal saline before and after each use followed by _____ mL heparin 100 unit/mL after final normal saline flush. Flush with 10-20 mL normal saline followed by _____ mL heparin 100 unit/mL or every month when not in use.	*Refill PRN*

Catheter care maintenance and removal

☐ Alteplase 2 mg vial: ≥30 kg: Instill 2 mg per lumen intracatheter as needed for occlusion; <30 kg: Instill a volume equal to 110% of internal lumen volume. Retain in catheter for a minimum of 30 minutes and withdraw. *Refill PRN*

☒ Skilled nurse to administer and/or teach to independence as well as provide assessment, vital sign measurement, and dressing changes weekly and PRN.

☐ Remove PICC/Midline upon completion of IV therapy regimen.

Lab monitoring

Labs to be drawn	Frequency	Send results to	☐ No labs

Physician authorization

I certify that the treatment above is medically necessary with supporting documentation in the patient's medical record. This message is intended for the sole use of the individual and entity to whom it is addressed, and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If you are not the intended addressee, nor authorized to receive for the intended addressee, you are hereby notified that you may not use, copy, disclose or distribute to anyone the message or any information contained in the message. If you have received this message in error, please immediately advise the sender by reply email and delete the message.

Physician signature		Print name		Date
Address	Phone	Fax		NPI

Fax completed forms to 877-290-2050. Questions? Call us at 877-290-2040.