

Patient Name: _____

Date of Birth: _____

Height: _____ Weight: _____ Allergies: _____

Implanted Intrathecal Pump Order Form

◆ Orders are initiated unless crossed out by provider.

Check box to initiate order.

Fax completed form to (360)933-1197. Call our pharmacists for therapy recommendations.

Diagnoses: _____ ICD-10: _____

Medication Order: (to fill implanted intrathecal pump)

****All medications and diluents must be preservative free****

- Morphine: _____ mg/ml mg total Rate: _____ mg/day
- Hydromorphone: _____ mg/ml mg total Rate: _____ mg/day
- Clonidine: _____ mcg/ml mcg total Rate: _____ mcg/day
- Bupivacaine: _____ mg/ml mg total Rate: _____ mg/day
- Baclofen: _____ mcg/ml mcg total Rate: _____ mcg/day
- Other: _____ mg/ml mg total Rate: _____ mg/day

Total Volume: _____

- ◆ Lidocaine 1% - up to 0.2ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).
- ◆ Infusion Reaction Management per Infusion Solutions protocol as needed.

Medication				
Daily Dose				
Patient administered dose (mg or mcg)				
Patient administered duration (h:m)				
Lockout interval (h:m)				
Dose restriction interval (#doses per h:m)				
Maximum activations per day				
Total max daily dose (Daily +PA)				

Nursing Orders:

- RN to interrogate, refill, and reprogram intrathecal pump as appropriate
- Other: _____

Lab Orders:

_____ every _____

Prescriber Signature

Date

Print Name

DEA Number