Infusion Solutions Inc.
Home Infusion & Specialty Pharmacy
477 W. Horton Rd
Bellingham, WA 98226
Phone (360) 933-4892
Fax (360) 933-1197

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.

Complete table below for patient-administered (PA) doses (leave blank if simple continuous infusion only)

Medication				
Patient administered dose (mg or mcg)				
Max daily dose (Daily +PA, mg or mcg)				
Duration (hr or min)				
Lockout interval (hr or min)				
Maximum activations (/day)				
Dose restriction interval (#doses/h:m)				

Nursing Orders:

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

Lab Orders:

- ❑ _____ every _____

_____ _____
Prescriber Signature *Date*

_____ _____
Print Name *DEA Number*