Infusion Therapy Order Form

Infusion Solutions Inc.
Home Infusion & Specialty Pharmacy

477 W Horton Rd
Bellingham, WA 98226
Phone (360) 933-4892
Fax (360) 933-1197

Please fax this form, copies of insurance cards, and supporting clinical documentation to **(360) 933-1197** to facilitate a swift and easy referral.

For therapy recommendations, please call our office and ask for a pharmacist.
Thank you for choosing Infusion Solutons!

DEMOGRAPHICS

Patient Name: _____ Date of Birth: _____ Gender: ☐F ☐M

Home Phone: _____ Cell: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Legally Responsible Representative: _____ Relationship to Patient: _____

FINANCIAL INFORMATION

**Please fax a copy of front and back of all insurance cards if available.

Payor: _____ ID#: _____ Group#: _____

Cardholder: _____ ☐ Self ☐ Spouse ☐Parent ☐Other:_____

ORDERS

Height: _____ **Weight:** _____ **Allergies:** _____

Diagnoses: _____ ICD-10:_____
_____ ICD-10:_____

Medication Orders:

☐ Medication/Dose: _____ Route: ☐IV☐SQ☐Other:_____
Instructions: _____ Duration of therapy: _____☐TBD (≤1 yr)

☐ Medication/Dose: _____ Route: ☐IV☐SQ☐Other:_____
Instructions: _____ Duration of therapy: _____☐TBD (≤1 yr)

☐ Clinical pharmacist to monitor drug levels and adjust dose accordingly
☒ Alteplase 2mg IV to declot central IV access per Infusion Solutions protocol as needed for occlusion.
☒ Flush line with D5W, 0.9% NaCl and/or Heparin 10 units/ml or 100 units/ml per Infusion Solutions protocol.
☒ 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.

Nursing Orders:

☒ RN to use central IV access or insert peripheral IV and rotate site every 3 to 7 days or as needed.
☐ Other: _____

Lab Orders:

☐ _____ ☐One time ☐ weekly ☐ every _____
☐ _____ ☐One time ☐ weekly ☐ every _____

_____ _____
Prescriber Signature *Date*

_____
Please Print Name