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*

Form # 334
https://hinet1pc.sharepoint.com/sites/InfusionSolutions/Shared Documents/General/Forms/300 - PHARMACY/F334 - Intrathecal Pump Order Form.docx