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: _____ Weight: _____

IV Access: _____ Height:_____

Allergies: _____

Address: _____

Patient Controlled Analgesia Order Form

MAKE SURE TO COMPLETE ALL SECTIONS OF THIS FORM FOR A VALID CII ORDER
Please fax this form, copies of insurance cards, demographics, and supporting clinical documentation to **(360) 933-1197** to facilitate an efficient referral. Thank you for choosing Infusion Solutions!

Diagnoses: _____ ICD-10: _____

Medication:

☐ Morphine Sulfate ☐ Hydromorphone HCl ☐ Fentanyl

☐ Other: _____

Administration Route: ☐IV ☐ Subcutaneous ❑ Intrathecal

Dosing Parameters:

A. Basal rate: _____ ☐mg/hour ☐mcg/hour ☐ml/hour

B. Patient controlled bolus dose (PRN): _____ ☐mg ☐mcg

C. Bolus dosing interval: ☐ Every 10 min ☐ Every 15 min ☐ Other: _____

D. Total quantity to dispense with this order: _____ ☐ Days supply (max 60) ☐ mg ☐mcg

E. Titrate to comfort to a maximum ___ ☐mg/hour ☐mcg/hour, with a ___% bolus every ___minutes

(**Titration orders strongly recommended for Hospice patients)

F. Is patient terminal? ☐Yes ☐No (**Yes is required for pharmacy to dispense >1 time using this order)

☒ Alteplase 2mg IV to declot central IV access per Infusion Solutions protocol as needed for occlusion.
☒ Flush line with 0.9% NaCl, D5W 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:

☐ If no central IV access: RN to insert peripheral IV or subcutaneous catheter, and rotate site as needed.
☐ May use lidocaine 1%, 0.1ml intradermally to start IV if needed.
☐ Perform weekly dressing change to intrathecal site and monthly pall filter changes, reprogram pump prn.
☐ Other: _____

_____ _____
Prescriber Signature *Date*

_____ _____
Print Name *DEA Number*

_____
Prescriber Address

KEY: ☒ Orders are initiated unless crossed out by provider. **❑ Check box to initiate order.**

Form # 318
Updated 1/20/2025 -AF