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:________
Allergies:__________________________Height:________
Address:____

Implanted Intrathecal Pump Order Form

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 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:

- ❑ ____

______________________________________ *Prescriber Signature*
____________________ *Date*

______________________________________ *Print Name*
____________________ *DEA Number*

____ *Prescriber Address*

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