Comanche County Memorial Hospital

Outpatient Infusion Center
IV Order

Please fax form to: 580-585-5472

Patient Information

Patient Name: DOB: Phone: Gender: ○ M ○ F

Patient Address: Email: Insurance:

Additional Information Needed

☐ Fax front/back of insurance card ☐ Fax clinical/progress notes ☐ Fax labs
☐ Fax patient demographics ☐ Fax current medication list ☐ Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

☐ E86.0 Dehydration
☐ E87.8 Electrolyte and Fluid Imbalance
☐ K52.29 Other Allergic and Dietic Gastroenteritis and Colitis
☐ O21.0 Mild Hyperemesis Gravidarum
☐ R11.2 Nausea with Vomiting, Unspecified
☐ Other: DX: _____

Clinical Information:

☐ New Therapy Induction ☐ Therapy Change ☐ Therapy Continuation
☐ Patient Weight: _____ lbs/ _____ kg ☐ Patient Height: _____ in/ _____ cm
☐ Allergies: _____
☐ Therapies Tried and Failed: _____
☐ TB Test: Date: _____ Results: _____ ☐ Hep B Test: Date: _____ Results: _____
☐ Does the patient have venous access? Yes or No If yes, What type? _____
If No, initiate IV access.

Lab Orders

☐ CBC w/o diff ☐ CMP ☐ ESR ☐ CRP
☐ Other: _____

Lab Orders to be done by

☐ Infusion Services
☐ Referring Provider

Prescription Information

☐ Zofran IV	☐ Dose: ☐ 4mg ☐ 8mg	☐ Frequency: Every: _____
☐ Reglan IV	☐ Dose: ☐ 10mg	☐ Frequency: Every: _____
☐ Pepcid IV	☐ Dose: ☐ 20mg	☐ Frequency: Every: _____
☐ 0.9% NaCl	☐ Dose:	☐ Frequency: Every: _____ Rate: _____
☐ 0.45% NaCl	☐ Dose:	☐ Frequency: Every: _____ Rate: _____
☐ LR	☐ Dose:	☐ Frequency: Every: _____ Rate: _____
☐ D5LR	☐ Dose:	☐ Frequency: Every: _____ Rate: _____
☐ Other	☐ Medication: _____	Dose: _____ Frequency: _____

Misc Orders

☐ _____
☐ _____

☐ PICC/Midline/CAD dressing to be changed every 7 days

Flushes

☐ 10mL NS Flush Syringe PRN
☐ Heparin 500units/5mL Flush Syringe PRN
☐ 50ml NS Bag PRN
☐ 250ml NS Bag PRN

Standing Orders for Adverse Reaction

☐ Stop infusion and initiate NS bolus
☐ Notify Supervising physician and ordering provider
☐ Solu-Cortef 100mg SIVP signs of adverse reaction
☐ Benadryl 25 mg SIVP for hives or bronchial inflammation
☐ Epi 1:1000 1mL IM, IV or SQ for anaphylaxis
☐ Oxygen 2-5L nasal cannula
☐ Albuterol 2.5mg inhaled PRN to chest tightness
☐ Other: _____

Prescriber Information

Physician Name: _____ Official Contact Name: _____
Contact #: _____ Fax Number: _____
Address: _____ City/State/Zip: _____
NPI#: _____ DEA#: _____ State License #: _____

_____ _____
Physician's Signature Date Time