Comanche County Memorial Hospital

**Outpatient Infusion Center**
**Vitamin C 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 patient demographics
- ☐ Fax clinical/progress notes
- ☐ Fax current medication list
- ☐ Fax labs
- ☐ Fax TB and Hep B results

## Diagnosis and Clinical Information

**Diagnosis (ICD-10):**

- ☐ DX: _____
- ☐ DX: _____
- ☐ DX: _____

**Clinical Information:**

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

## Lab Orders

- ☐ CBC w/o diff
- ☐ Ferritin
- ☐ Iron/IBC
- ☐ Other: _____

**Lab Orders to be done by**

- ☐ Infusion Services
- ☐ Referring Provider

## Prescription Information

- ☐ Vitamin C
  - ☐ Initial Dose: _____g
  - ☐ Maintenance Dose: _____g every _____

## 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