Provide Patient Identification: Patient Name;
Medical Record Number;
Date of Birth

PeaceHealth
Peace Harbor Medical Center

Clarify or Discontinue Existing Orders
Outpatient Infusion Therapy Plan

All Pre-Selected Boxed Orders Are Initiated by Default Unless Crossed Out by Practitioner. All Boxed Orders Require Practitioner Check to be Initiated.

Heading	Content
Orders	**Clarification to existing orders:** _____ _____ _____ _____ **Discontinue orders:** _____ _____ _____ _____
Provider Contact	Ordering Provider Name (please print): _____ Phone Number: _____ Office Location: _____ FAX: _____
PHMC Outpatient Infusion Contact Information	**PROVIDER – PLEASE SIGN, DATE AND TIME ORDERS AND RETURN TO:** **PeaceHealth Peace Harbor Medical Center** **Peace Harbor Hospital Outpatient Infusion Services Department** 400 Ninth Street Florence, OR 97439 Contact Phone: 541-902-6019 ***FAX 541-902-1649***
Authorization by Verbal or Telephone Order	Person giving verbal or telephone order: _____ Person receiving verbal or telephone order: _____ ☐ Check to indicate verbal or telephone orders have been read back to confirm accuracy

Practitioner Signature: _____Date of Order: _____Time: _____

Orders must include signature of the ordering practitioner, date and time.