



Thank you for selecting our infusion services team to care for your patient. If you are not a PeaceHealth provider, all information listed below is required before we can process orders and schedule your patient for treatment.

**Part A- Patient scheduling and contact information:**

Patient Name (Last, First): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Contact Information and Phone Number (s): \_\_\_\_\_

Ordering Provider Name (Print): \_\_\_\_\_

Provider Clinic or Service Address: \_\_\_\_\_

Clinic or Service Phone Number: \_\_\_\_\_ Clinic or Service Fax Number: \_\_\_\_\_

Diagnosis (include ICD 10 codes): \_\_\_\_\_

Medication and Service Requested- list J-Code/ CPT code if known: \_\_\_\_\_

**Date Service is Requested to Begin:** \_\_\_\_\_ **Date Service is Expected to End:** \_\_\_\_\_

*Order will expire 1 year from date of provider signature unless "date service is expected to end" is earlier.*

**Part B- Insurance and Prior Authorization.** Any non-PeaceHealth provider must obtain prior authorization prior to service. Attach a copy of authorization documentation received from insurance payer when submitting orders.

Insurance (Payer) Company: \_\_\_\_\_

Prior Authorization Number and Conditions: \_\_\_\_\_

Prior Authorization Expiration Date: \_\_\_\_\_

Insurance (Payer) Contact Phone Number: \_\_\_\_\_

**Part C- Elements needed to guide medication therapy are included with request for service:**

- All orders and instruction (please use the PeaceHealth approved ordering form) are complete and include provider signature AND printed name at the bottom of each order page. Check the boxes of ALL orders you would like to activate.
- For blood products, PeaceHealth Blood and Transfusion Consent form is signed and dated by the provider and the patient.

**If information is located outside of PeaceHealth's electronic medical record system attach the following:**

- A list of current medications reconciled by patient provider is available and includes a list of known allergies.
- Recent progress notes from ordering provider.
- A copy of relevant laboratory results and other appropriate supporting documentation.

**IMPORTANT MESSAGE TO PROVIDERS:** To reduce delays in treatment and phone calls to your office you may participate in the PHMC formulary process by signing this document. A clinical pharmacist will adjust orders according to PHMC approved policies and procedures.

*I agree to utilize PHMC policies & procedures that have been reviewed by the Pharmacy & Therapeutics Committee and authorized by the Medical Executive Committee of PHMC. This agreement will be issued for the duration of active orders contained within this treatment plan.*

**PROVIDER SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_ **TIME:** \_\_\_\_\_

**FAX completed service request and completed orders to: PHMC OP Infusion and Nursing Services 541-902-1649**



## Intravenous Hydration or Potassium Replacement-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						
<p><b>Supportive Care</b></p>	<p><b>Hydration:</b>  <b>Select one of the following options:</b></p> <table border="1"> <tr> <td><input type="checkbox"/> Normal Saline (NS) _____ mL, IV continuous, at _____ mL/hr</td> </tr> <tr> <td><input type="checkbox"/> Lactated Ringers (LR) _____ mL, IV continuous, at _____ mL/hr</td> </tr> <tr> <td><input type="checkbox"/> Dextrose 5% (D5) _____ mL, IV continuous, at _____ mL/hr</td> </tr> <tr> <td><input type="checkbox"/> D5 NS _____ mL, IV continuous, at _____ mL/hr</td> </tr> <tr> <td><input type="checkbox"/> D5 ½ NS _____ mL, IV continuous, at _____ mL/hr</td> </tr> <tr> <td><input type="checkbox"/> Other: _____</td> </tr> </table> <p><b>Potassium Containing IV Fluids:</b></p> <p><input type="checkbox"/> Potassium chloride 20 mEq IV  <input type="checkbox"/> Potassium chloride 40 mEq IV</p> <p><b>Select Frequency of Administration:</b></p> <p><input type="checkbox"/> Once  <input type="checkbox"/> Other: _____</p>	<input type="checkbox"/> Normal Saline (NS) _____ mL, IV continuous, at _____ mL/hr	<input type="checkbox"/> Lactated Ringers (LR) _____ mL, IV continuous, at _____ mL/hr	<input type="checkbox"/> Dextrose 5% (D5) _____ mL, IV continuous, at _____ mL/hr	<input type="checkbox"/> D5 NS _____ mL, IV continuous, at _____ mL/hr	<input type="checkbox"/> D5 ½ NS _____ mL, IV continuous, at _____ mL/hr	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Normal Saline (NS) _____ mL, IV continuous, at _____ mL/hr							
<input type="checkbox"/> Lactated Ringers (LR) _____ mL, IV continuous, at _____ mL/hr							
<input type="checkbox"/> Dextrose 5% (D5) _____ mL, IV continuous, at _____ mL/hr							
<input type="checkbox"/> D5 NS _____ mL, IV continuous, at _____ mL/hr							
<input type="checkbox"/> D5 ½ NS _____ mL, IV continuous, at _____ mL/hr							
<input type="checkbox"/> Other: _____							
<p><b>Nursing IV Access and Maintenance</b></p>	<p><b>Select the most appropriate option below:</b></p> <p><input checked="" type="checkbox"/> <b>Insert PERIPHERAL IV</b> as needed and flush (unless provider selects option for a central line).  <input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) flush 10 mL IV once as needed for line care.</p> <p><input type="checkbox"/> <b>Access and use NON-PICC Central Line/CVAD</b></p> <p><input checked="" type="checkbox"/> Initiate Central Line (non-PICC) maintenance protocol.  <input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) flush 10 mL IV as needed for line care, before and after medication administration, at discharge, and at de-access (sterile NS for Port-a-Cath access).  <input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) flush 20 mL IV as needed for line care post lab draw.  <input checked="" type="checkbox"/> Heparin, porcine (PF) 100 unit/mL flush 5 mL IV as needed for line care, for de-access.</p> <p><input type="checkbox"/> <b>Access and use PICC Central Line/CVAD</b></p> <p><input checked="" type="checkbox"/> Initiate PICC maintenance protocol.  <input checked="" type="checkbox"/> Change PICC line dressing weekly and as needed.  <input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) flush 10 mL IV as needed for line care, and before and after medication administration.  <input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) flush 20 mL IV as needed for line care post lab draw</p>						
<p><b>As Needed Medications</b></p>	<p><b>Standard As Needed Medications:</b></p> <p><input checked="" type="checkbox"/> Sodium chloride 0.9% (NS) flush 10 mL IV as needed for line care.  <input checked="" type="checkbox"/> Sodium chloride 0.9% 500 mL continuous infusion at 25 mL/hour IV as needed for therapy administration (i.e., blood products, chemotherapy, potassium administration).  <input checked="" type="checkbox"/> Alteplase (Cathflo) injection 2 mg intra-catheter as needed for occluded central line catheters- Retain in catheter for 30 minutes to 2 hours; may instill a second dose if occluded. IRRITANT. Refrigerate.</p>						
<p><b>Emergency Medications</b></p>	<p><b>If patient has symptoms of anaphylaxis (wheezing, dyspnea, hypotension, angioedema, chest pain, or tongue swelling), discontinue infusion and initiate standard emergency response procedures.</b></p>						

Sensitivity: General Business Use. This document contains proprietary information and is intended for business use only.

**Practitioner Signature:** \_\_\_\_\_ **Date of Order:** \_\_\_\_\_ **Time:** \_\_\_\_\_

Final page of orders must include signature of the ordering practitioner, date, and time.



## Intravenous Hydration or Potassium Replacement-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
	<p><b>Standard Emergency Medications:</b></p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> <b>DiphenhydrAMINE (Benadryl) injection</b> 25-50 mg IV once as needed for mild to moderate drug reactions (flushing, dizziness, headache, diaphoresis, fever, palpitations, chest discomfort, blood pressure changes (&gt;/= 20 points in SBP), nausea, urticaria, chills, pruritic).                             <ul style="list-style-type: none"> <li>• Administer 50 mg IV if patient has NOT had diphenhydramine within 2 hours of reaction.</li> <li>• Administer 25 mg IV if patient has had diphenhydramine within 2 hours of reaction, if reaction doesn't resolve in 3 minutes may repeat 25 mg IV dose for a total of 50 mg and contact provider.</li> </ul> </li> <li><input checked="" type="checkbox"/> <b>Albuterol 90 mcg/actuation inhaler</b> 2 puffs once as needed for wheezing, shortness of breath associated with infusion reaction and contact provider. Administer with a spacer if available.</li> <li><input checked="" type="checkbox"/> <b>MethylPREDNISolone (Solu-Medrol) injection</b> 125 mg IV once as needed for shortness of breath for continued symptoms of mild to moderate drug reactions (flushing, dizziness, headache, diaphoresis, fever, palpitations, chest discomfort, blood pressure changes (&gt;/= 20 points in SBP), nausea, urticaria, chills, pruritic) that worsen or persist after administration of diphenhydramine (Benadryl) and contact provider.</li> <li><input checked="" type="checkbox"/> <b>EPINEPHrine (Adrenalin) injection</b> 0.5 mg IM once as needed for severe drug reaction (flushing, dizziness, headache, diaphoresis, fever, palpitations, chest discomfort plus blood pressure changes (&gt;/= 40 points in SBP), shortness of breath with wheezing and O2 Sat &lt; 90%) and contact provider.</li> </ul>
<b>Referral</b>	<input checked="" type="checkbox"/> Ambulatory referral to OP Infusion Services
<b>PHMC Outpatient Infusion Contact Information</b>	<p><b>PROVIDER – PLEASE SIGN, DATE AND TIME ORDERS AND RETURN TO:</b></p> <p><b>PeaceHealth Peace Harbor Medical Center Outpatient Infusion Services Department</b>                      400 Ninth Street, Florence, OR 97439                      Contact Phone: 541-902-6019 and FAX <b>541-902-1649</b></p>
<b>Authorization by Verbal or Telephone Order</b>	<p>Person giving verbal or telephone order: _____</p> <p>Person receiving verbal or telephone order: _____</p> <p><input type="checkbox"/> Check to indicate verbal or telephone orders have been read back to confirm accuracy</p>

Sensitivity: General Business Use. This document contains proprietary information and is intended for business use only.  
 Sensitivity: General Business Use. This document contains proprietary information and is intended for business use only.

**Practitioner Signature:** \_\_\_\_\_ **Date of Order:** \_\_\_\_\_ **Time:** \_\_\_\_\_

*Final page of orders must include signature of the ordering practitioner, date, and time.*