PRGORD Progress & Order

PeaceHealth

Peace Harbor Medical Center
Outpatient Infusion Service Request

Phone: (541) 902-6019 Fax: (541) 902-1649

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

PeaceHealth

Blood Transfusion CONSENT and REFUSAL

PROPOSED TREATMENT

I understand that I may need a transfusion as part of my treatment. This transfusion may be needed for blood loss due to injury, hemorrhage, disease or surgery, treatment for cancer, leukemia, or various blood diseases, replacing blood or blood products that my body is unable to produce.

Blood products may include any of the following parts depending on my medical condition.

- Red cells to carry oxygen to tissues or organs
- Platelets, plasma, and factor concentrates to promote clotting
- White cells to fight infection

I understand that when my health care provider decides I need a transfusion, a small blood sample will be collected and labeled for testing before any transfusion to ensure I am receiving a unit matched for me.

RISKS AND SIDE EFFECTS

There are risks and possible side effects (reactions) caused by a transfusion of blood or blood products. Known reactions to transfusions include, but are not limited to:

- Bruising, chills, fever, skin rash, and hives.

Less common but more serious reactions include:

- Fluid in the lungs, shortness of breath.

Very rare but severe reactions include kidney failure, low blood pressure and shock, transmissions of diseases such as hepatitis, HIV, or AIDS, and developing a bacterial infection.

❑ GENERAL INFORMATION FOR MINORS

Parent or Guardian Initial: _____

As the parent/guardian of a minor child I understand that the provider(s) treating my minor child will make best efforts to respect my beliefs regarding the transfusion of blood products. The providers will make their best efforts to treat my minor child without the use of blood.

PeaceHealth

Blood Transfusion CONSENT and REFUSAL

CONSENT FOR TRANSFUSION OF BLOOD PRODUCTS

My health care provider has explained that I may benefit from a transfusion of blood products. He/she has explained the risks and possible side effects of receiving blood or blood products as described above.

I understand that PeaceHealth Transfusion Services and the blood and blood product supplier take safety measures to make the risks as small as possible.

Other options to transfusion, including no treatment, have been explained to me.

I am satisfied with the way the benefits, risks, possible side effects and other options were explained to me and that I have had a chance to get answers to my questions. My questions were answered to my satisfaction.

I understand the contents of this form and I agree to the transfusion of blood and blood products.

Signature of patient		Date	Time
Signature of person authorized to sign for patient – Relationship		Date	Time
Caregiver (witness) signature	3x3	Date	Time
Provider signature	3x3	Date	Time

For staff use only:
Was Interpreter utilized? ❑ Yes ❑ No
If yes (and remote), Interpreter name: _____
Interpreter #:
If yes (and present), _____
Interpreter signature 3x3 (if applicable) Date Time

PeaceHealth

Blood Transfusion CONSENT and REFUSAL

REFUSAL OF TRANSFUSION OF BLOOD PRODUCTS

❑ I refuse blood products to be transfused.

❑ I refuse blood products except for:

❑ _____ ❑ _____ ❑ _____ ❑ _____

- I request this even though in the opinion of my health care provider, such blood products may be needed to preserve life or promote recovery.
- I understand that refusal to consent to life-saving treatment for my minor child based on religious beliefs may not be protected under federal or state laws and that I may be held criminally liable if my minor child is harmed because of my refusal
- I further understand that my minor child's medical team may seek a court order to provide necessary life-saving treatment if I refuse to give my informed consent.
- I hereby release PeaceHealth and my health care providers from any responsibility for any unwanted effects from my refusal of blood products.

Signature of patient		Date	Time
Signature of person authorized to sign for patient – Relationship		Date	Time
Caregiver (witness) signature	3x3	Date	Time
Provider signature	3x3	Date	Time

For staff use only:
Was Interpreter utilized? ❑ Yes ❑ No
If yes (and remote), Interpreter name: _____
Interpreter #: _____
If yes (and present), _____
Interpreter signature 3x3 (if applicable) Date Time

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Change order details by crossing out unwanted information and writing in desired details/instructions. Place a line through the ~~[X]~~ to remove the pre-check option.

OP Blood Transfusion Smart Set [3040000654]

Provider: Patient consent must be completed and signed before transfusion orders can be processed.
Please sign and **return all 3 pages of consent** with the completed transfusion orders.

Nursing

CVAD OR PERIPHERAL IV ACCESS (Single Response)	
( ) Access & Use Central Line/CVAD	Routine, As needed, Starting Today For Until specified, OP Blood Infusion Device Type: External Location:
(X) Insert peripheral IV	Routine, Once For 1 Occurrences, OP Blood Infusion

Labs

Blood Bank Test	
[ ] Type And Screen	Status: Standing, Expires:Y+1 Manual,Count:1, Clinic Collect, Blood, Pre-Admission Testing
Pre-Transfusion Labs	
[ ] Hemoglobin - Pre-Transfusion	Status: Standing, Expires:Y+1 Manual,Count:1, Clinic Collect, Pre-Admission Testing
[ ] CBC, No Differential - Pre-Transfusion	Status: Standing, Expires:Y+1 Manual,Count:1, Clinic Collect, Pre-Admission Testing
[ ] Protime-INR - Pre-Transfusion	Status: Standing, Expires:Y+1 Manual,Count:1, Clinic Collect, Pre-Admission Testing
[ ] PTT - Pre-Transfusion	Status: Standing, Expires:Y+1 Manual,Count:1, Clinic Collect, Pre-Admission Testing
[ ] Fibrinogen - Pre-Transfusion	Status: Standing, Expires:Y+1 Manual,Count:1, Clinic Collect, Pre-Admission Testing
Post-Transfusion Labs	
[ ] Hemoglobin - Post-Transfusion	Status: Standing, Expires:Y+1 Manual,Count:1, Clinic Collect, Pre-Admission Testing
[ ] CBC, No Differential - Post-Transfusion	Status: Standing, Expires:Y+1 Manual,Count:1, Clinic Collect
[ ] Protime-INR - Post-Transfusion	Status: Standing, Expires:Y+1 Manual,Count:1, Clinic Collect, Pre-Admission Testing
[ ] PTT - Post-Transfusion	Status: Standing, Expires:Y+1 Manual,Count:1, Clinic Collect, Pre-Admission Testing
[ ] Fibrinogen - Post-Transfusion	Status: Standing, Expires:Y+1 Manual,Count:1, Clinic Collect, Pre-Admission Testing

Line Care

Line Care (Hep Lock Flush 100u/ml, NS Flush, Lidocaine 1%, Alteplase 2mg)	
[X] heparin, porcine (PF) 100 unit/mL flush	3-5 mL, IV, As Needed, Line Care, OP Blood Infusion To flush Hickman or PICC with 3mL. To flush Port-a-Cath 5mL.

Provider Signature

Date and Time:

OP BLOOD TRANSFUSION SMART SET

Prog & Orders

Place patient label here

[X] sodium chloride 0.9 % injection	10 mL, IV, As Needed, Other, Line Care, OP Blood Infusion Sterile NS for Port-a-Cath access.
[ ] lidocaine (PF) (XYLOCAINE-MPF) 10 mg/mL (1 %) injection	0.25 mL, Infiltration, Once, For 1 Doses, OP Blood Infusion
[ ] alteplase (CATHFLO) injection	2 mg, Intra-Catheter, As Needed, Other, Occluded Catheter, For 2 Doses, OP Blood Infusion Retain in catheter for 30 minutes-2 hours; may instill a second dose if still occluded.

Blood Products

Blood Products

[ ] Adult Blood Administration - Red Blood Cells	
[X] Prepare RBC	Routine, Best practice is to order one unit. If the patient has positive antibodies, prepare a replacement of 1 unit to have available., Pre-Admission Testing Patient Type: Adult Transfusion Indications: Number of Units: Expected Date of Transfusion: Expected Location of Transfusion: Special Requirements:
[X] Transfuse RBC	Routine, OP Blood Infusion
[ ] Adult Blood Administration - Platelets	
[X] Prepare Platelet Dose	Routine, Pre-Admission Testing Patient type: Adult Number of Units: Transfusion Indications: Expected Date of Transfusion: Expected Location of Transfusion: Special Requirements:
[X] Transfuse platelets	Routine, OP Blood Infusion
[ ] Adult Blood Administration - Fresh Frozen Plasma	
[X] Prepare Plasma	Routine, Pre-Admission Testing Patient Type: Adult Number of Units: Transfusion Indications: Expected Date of Transfusion: Expected Location of Transfusion: Special Requirements:
[X] Transfuse fresh frozen plasma	Routine, OP Blood Infusion
[ ] Adult Blood Administration - Pooled Cryoprecipitate	
1 pooled unit = 5 single units, and is expected to increase fibrinogen by 37 mg/dL in a 70 kg adult	
[X] Prepare Pooled Cryoprecipitate	Routine, 1 pooled unit = 5 single units, and is expected to increase fibrinogen by 37 mg/dL in a 70 kg adult, Pre-Admission Testing Patient Type: Adult Number of Pooled Units: Transfusion Indications: Expected Date of Transfusion: Expected Location of Transfusion: Special Requirements:
[X] Transfuse cryoprecipitate	Routine, OP Blood Infusion

Provider Signature

Date and Time:

Place patient label here

Medications

Pre-Transfusion Medications	
[X] sodium chloride 0.9 % bolus	20 mL, IV, Administer over: 15 Minutes, As Needed, for PRIMING and FLUSHING of blood administration tubing, OP Blood Infusion Hold maintenance infusion while bolus is infusing? Yes
[ ] furosemide (LASIX) IV 20 mg	20 mg, IV, Once, For 1 Doses, OP Blood Infusion Give once prior to transfusion.
[ ] acetaminophen (TYLENOL) tablet 650 mg	650 mg, Oral, Once, For 1 Doses, OP Blood Infusion Give once prior to transfusion.
[ ] diphenhydrAMINE (BENADRYL) capsule 25 mg	25 mg, Oral, Once, For 1 Doses, OP Blood Infusion Give once prior to transfusion.
[ ] diphenhydrAMINE (BENADRYL) IV 25 mg	25 mg, IV, Once, For 1 Doses, OP Blood Infusion Give once prior to transfusion.
[ ] diphenhydramine (BENADRYL) oral liquid	12.5 mg, Oral, Once, For 1 Doses, OP Blood Infusion Give once prior to transfusion.
During Transfusion Medications	
[ ] furosemide (LASIX) IV 20 mg	20 mg, IV, Once, For 1 Doses, OP Blood Infusion Give between units.
Post-Transfusion Medications	
[X] sodium chloride (NS) 0.9 % flush	3-10 mL, IV, As Needed, Line Care, OP Blood Infusion Peripheral - flush with 3 ml; Central Line - flush with 10 ml.
[ ] furosemide (LASIX) IV 20 mg	20 mg, IV, Once, For 1 Doses, OP Blood Infusion Give once after transfusion.
Standard Emergency Meds - Adult	
[X] diphenhydrAMINE (BENADRYL) injection	25-50 mg, IV, Once As Needed, Other, Mild to moderate drug reactions, For 1 Doses, OP Blood Infusion Flushing, dizziness, headache, diaphoresis, fever, palpitations, chest discomfort, blood pressure changes (>/= 20 points in SBP), nausea, urticaria, chills, pruritis. Administer 50mg IV if patient has NOT had diphenhydramine within 2 hours of reaction. Administer 25mg IV if patient has had diphenhydramine within 2 hours of reaction, if reaction doesn't resolve in 3 minutes may repeat 25mg IV for a total dose of 50mg, and contact provider.
[X] EPINEPHrine (ADRENALIN) injection	0.5 mg, Intramuscular, Once As Needed, Other, Flushing, dizziness, headache, diaphoresis, fever palpitations, chest discomfort plus blood pressure changes (>/= 40 points in SBP), shortness of breath with wheezing and O2Sat <90%), and contact provider., For 1 Doses, OP Blood Infusion
[X] methylPREDNISolone sodium succinate (Solu-MEDROL) injection	125 mg, IV, Once As Needed, Other, shortness of breath for continued symptoms of mild to moderate drug reactions, For 1 Doses, OP Blood Infusion Flushing, dizziness, headache, diaphoresis, fever, palpitations, chest discomfort, blood pressure changes (>/= 20 points in SBP), nausea, urticaria, chills, pruritis that worsen or persist 5 minutes after administration of diphenhydramine (Benadryl), and contact provider.

Provider Signature

Date and Time:

Place patient label here

[ ] albuterol 90 mcg/actuation inhaler	1-3 puff, Inhalation, Once As Needed, Wheezing, Shortness of Breath, shortness of breath associated with infusion reaction and contact provider, For 1 Doses, OP Blood Infusion Administer with a spacer if available.

Referral

PH Referral to Infusion Therapy (Blood Tx Default)

[X] Ambulatory referral to Infusion Therapy	Internal Referral

Provider Signature	EHR User ID	Date	Time

Place patient label here