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

Patient Identification Label

PeaceHealth
Peace Harbor Medical Center

Magnesium
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
Supportive Care	**Choose one of the following**: ☐ Magnesium sulfate _____ gram IV **once** ☐ Magnesium sulfate IV **weekly** based on lab value. Check lab results prior to releasing this order: • For magnesium level 1.5-1.9 mg/dL: give 2 grams magnesium sulfate IV • For magnesium level 0.9-1.4 mg/dL: give 4 grams magnesium sulfate IV • For magnesium level less than 0.9 mg/dL: start 4 grams magnesium sulfate IV and call provider for additional orders
Labs	☒ Magnesium level prior to each treatment ☒ Treatment lab instructions – Provider approves to release and draw labs 2 days pre and post this planned treatment date.
Nursing Orders	☒ Check serum magnesium weekly and infuse as follows weekly based on lab value: • 1.5-1.9 mg/dL: give 2 grams magnesium sulfate IV • 0.9-1.4 mg/dL: give 4 grams magnesium sulfate IV • < 0.9 mg/dL: start 4 grams magnesium sulfate IV and call provider for additional orders
Nursing IV Access and Maintenance	**Select the most appropriate option below:** ☒ **Insert PERIPHERAL IV** once as needed ☒ Sodium chloride 0.9% (NS) flush 10 mL IV once as needed for line care ☐ **Access and use NON-PICC Central Line/CVAD** as needed and confirm patency ☒ Initiate Central Line (Non-PICC) maintenance protocol ☒ Sodium chloride 0.9% (NS) injection 10 mL IV as needed for line care before and after medication administration, at discharge, and at de-access ☒ Sodium chloride 0.9% (NS) injection 20 mL IV once as needed for line care post lab draw ☒ Heparin, porcine (PF) 100 unit/mL flush 5 mL IV as needed for line care, for de-access ☒ Alteplase (Cathflo) injection 2 mg intra-catheter once as needed x 2 doses. For clearing central line catheter. Add 2.2 mL sterile water for injection to vial; let the vial stand undisturbed to allow large bubbles to dissipate. Mix by gently swirling until completely dissolved (complete dissolution should occur within 3 minutes); do not shake. Final concentration: 1 mg/mL. Retain in catheter for 30 minutes to 2 hours, instill a second dose if occluded. ☐ **Access and use PICC Central Line/CVAD** as needed and confirm patency ☒ Initiate PICC maintenance protocol ☒ Change PICC line dressing weekly and as needed ☒ Sodium chloride 0.9% (NS) injection 10 mL IV as needed for line care before and after medication administration ☒ Sodium chloride 0.9% (NS) injection 20 mL IV once as needed for line care post lab draw ☒ Alteplase (Cathflo) injection 2 mg intra-catheter once as needed x 2 doses. For clearing central line catheter.
As Needed Medications	☒ DiphenhydrAMINE (Benadryl) injection 50 mg IV as needed for itching or hives. May give an additional 50 mg PO or IV 4 hours after first dose. ☒ DiphenhydrAMINE (Benadryl) 50 mg PO as needed for itching or hives. May give an additional 50 mg PO or IV 4 hours after first dose.

Practitioner Signature: _____Date of Order: _____Time: _____

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

Patient Identification Label

PeaceHealth
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Heading	Content
	☒ Sodium chloride 0.9% (NS) flush 10 mL IV as needed for line care ☒ Sodium chloride 0.9% 500 mL continuous infusion IV once as needed at 25 mL/hour IV for line care
Referral	☒ Ambulatory referral to OP Infusion Services
PHMC Outpatient Infusion Contact Information	**PROVIDER – PLEASE SIGN, DATE AND TIME ORDERS AND RETURN TO:** **PeaceHealth Peace Harbor Medical Center Outpatient Infusion Services Department** 400 Ninth Street Florence, OR 97439 Contact Phone: 541-902-6019 and 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: _____

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