ALL ORDERS MUST BE SIGNED AND DATED BY THE REFERRING PROVIDER

ALLERGIES/REACTIONS (REQUIRED):

Yakima Outpatient Infusion Care
808 N 39th Ave Yakima WA 98902
Phone: 509-575-1174
Fax: 509-577-5021

ORDERS WITH CHECK BOXES	When an order is optional (those with check boxes), providers are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.
CODE STATUS	Patients will be considered FULL CODE unless marked otherwise. If the patient has a POLST, advance directive, or living will, please include a copy with the orders.

INFUSION CARE ORDERS

Patient Name:_____ Requested Start Date: _____/_____/_____

Date of Birth:_____/_____/_____ Patient Weight: _____ kg Patient Height: _____

Patient Phone Number: (_____)_____-_____

DIAGNOSIS & ICD-10 CODE: _____

REQUIRED: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs
If required documentation not received with this order, scheduling of treatment will be delayed until complete information is available

ACCESS: ❑ Peripheral IV ❑ PICC ❑ Port-A-Cath ❑ Other _____

Peripheral IV insertion & Maintenance flush catheter IV with 5 mL 0.9% sodium chloride before and after administration of medication and as necessary to keep line patent. Replace IV catheter as needed. Discontinue IV catheter upon completion of infusion therapy or when no longer necessary for the plan of care.
*Central Line Maintenance flush central line with 10 mL 0.9% sodium chloride before and after administration of medication and as necessary to keep line patent. Lock central line IV with 5 mL **10 unit/mL** heparin.*
*Port-A-Cath Maintenance flush central line intravenously with 10 mL 0.9% sodium chloride before and after administration of medication and as necessary to keep line patent. Lock Port-A-Cath IV with 5 mL **100 unit/mL** heparin (adults) or **10 unit/mL** heparin (pediatric).*

MAINTENANCE: ☑ Weekly & PRN Line Maintenance (PICC/Port-A-Cath) ☑ TPA (2 mg IV per lumen) if needed for occlusion

LABS (if needed, with frequency): _____

DRUG & DOSAGE *(another brand of drug, identical in form and content may be dispensed unless "DAW" or "BRAND ONLY" is written next to the drug name)*

#1.) _____

#2.) _____

FREQUENCY OF MEDICATION: #1.) _____

#2.) _____

LENGTH OF THERAPY (MAXIMUM 1 YEAR): #1.) _____

#2.) _____

ADDITIONAL INFORMATION/MONITORING: _____

SUPPORTIVE CARE: Administer hypersensitivity reaction/anaphylaxis management per MYMH OIC protocol as necessary.
DISCHARGE: 30 minutes after infusion or injection completion when vital signs are stable and hypersensitivity symptoms are absent. Can be waived by patient on subsequent infusions or injections.

Provider Signature: _____ Date: _____

Print name: _____ Phone # _____ Fax # _____

❑ NEW REFERRAL ❑ UPDATED REFERRAL ****Expires 12 months from written date****

Patient Identification - Attach Patient Label

Name:

MRN:

Age / Sex and Gender:

INFUSION CARE ORDERS

MultiCare

Yakima Memorial Hospital