ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

❑ Puyallup Infusion Center - Fax: 253-697-5066
❑ Gig Harbor Infusion Services - Fax: 253-530-8069
❑ Allenmore Ambulatory Infusion Services - Fax: 253-864-4052
❑ DHEC Infusion Center - Fax: 509-755-5845
❑ Auburn Infusion Services - Fax: 253-876-8282
❑ North Spokane Infusion Center - Fax: 509-232-2531

ORDERS WITH CHECK BOXES When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Infusion Center Orders

Patient Name:_____ Requested Date of Service: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Patient Phone Number: (_____) _____ - _____ ❑ May leave message

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 order, scheduling of treatment will be delayed until complete information is available

- Isolation type: ❑ Contact ❑ Other _____

☑ **IV Access:** Access and/or maintain IV site in accordance with MHS IV Therapy P&P: Peripheral IV Device Site Selection, Insertion, Maintenance, and Discontinuation; and Maintenance of Central Venous Catheters-Flushing, Dressing Changes and Removal.

Patient weight = _____ lb/kg (required if needed for dosing)

Blood products - initiate pre-printed blood product order set

❑ **Monthly port flush (every 4-6 weeks) for 12 months**

Lab/Diagnostics: ❑ CBC ❑ BMP ❑ CMP ❑ Other _____

Results: ❑ FAX: _____

Drug Name	Dose	Route	Frequency	Start Date	Stop Date

❑ Pharmacy consult for dosing

If hypersensitivity develops (fever, chills, hypotension, rigors, itching, rash, etc.):

- Consult MultiCare hypersensitivity guideline for treatment management
- Notify provider of reaction, assessment and need for futher orders

Code Status: Please note, 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.

Was consent obtained: ❑ Yes ❑ No (if yes, please send DOCUMENTATION of consent with order)

Provider Signature	Print Name	Date	Time

Another brand of drug, identical in form and content, may be dispensed unless checked ❑ **Order expires in 12 months****

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order
INFUSION CENTER ORDER

MultiCare

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