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.

AMBULATORY 5-FU PUMP OFF ORDER

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

Date of Birth:_____/_____/_____

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

ORDER:

Discontinue ambulatory 5-FU pump 46 hours after start
Flush PICC or Port-A-Cath per facility protocol
Discontinue Port needle if Port-A-Cath is accessed

FREQUENCY: Every 2 weeks

DURATION: ❑ 52 weeks | ❑ Other: _____ weeks

LINE MAINTENANCE:

❑ **CENTRAL LINE MAINTENANCE:**
Access per MYM procedure.
Flush central line intravenously with 0.9% sodium chloride 10 mL before and after administration of medication and as necessary to keep line patent.
Lock central line intravenously with 10 unit/mL heparin 5 mL.
TPA (2 mg/lumen) PRN for occlusion per protocol
De-access upon completion of infusion therapy or when no longer necessary for the plan of care per MYM procedure.

❑ **PORT-A-CATH MAINTENANCE:**
Access per MYM procedure.
Flush central line intravenously with 0.9% sodium chloride 10 mL before and after administration of medication and as necessary to keep line patent.
Lock Port-A-Cath intravenously with 100 unit/mL heparin 5 mL (adults) or 10 unit/mL heparin 5 mL (pediatric).
TPA (2 mg/lumen) PRN for occlusion per protocol
De-access upon completion of infusion therapy or when no longer necessary for the plan of care per MYM procedure.

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 5-FU PUMP OFF

MultiCare

Yakima Memorial Hospital