

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.

THERAPEUTIC PHLEBOTOMY

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

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

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

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)**.*

ROUTINE LABS: CBC w/ diff | Hemoglobin/Hematocrit | Ferritin | Other: _____

ROUTINE LAB FREQUENCY: Each Infusion | Other: _____

ADMINISTRATION PARAMETERS

HOLD phlebotomy if:

- Ferritin is less than _____ ng/dL
- Hemoglobin is less than _____ g/dL
- Hematocrit is less than _____ %
- Other: _____

THERAPEUTIC PHLEBOTOMY

- Amount to be removed: _____ mL (no more than 500 mL; 1 unit approx. 500 mL)

FREQUENCY (REQUIRED): _____ total doses | Weekly _____ | Monthly _____ | Other: _____

POST-PHLEBOTOMY HYDRATION (OPTIONAL):

- Sodium chloride 0.9% (normal saline) – 500 mL IV over 30 minutes
- HOLD HYDRATION IF: _____

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: _____

THERAPEUTIC PHLEBOTOMY



Yakima Memorial Hospital