

ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

Fax all infusions to: 833-380-8800
Please mark the appropriate infusion center:

- Allenmore Infusion Center
- Auburn Infusion Center
- Gig Harbor Infusion Services
- Puyallup Infusion Center
- DHEC Infusion Center
- North Spokane Infusion Center
- North Star Lodge Infusion Center

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

ICD -10 Code:

Diagnosis: _____ _____

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 further 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

