HOME INFUSION PHARMACY PRESCRIBER ORDER FORM							
TIOWIE IIVI							
Fax completed form, insurance information, and clinical documentation to:							
INTELLIGENT S HEALTH		Patient Name:				Date of Birth:	
COMPANY	Address:	Address:					
UBACARE	Phone:		Height:	$\square$ inches $\square$	cm Weight:	☐ Ibs ☐ kg	
Clinical Information							
Primary Diagnos	is Description:	ICD-10 Code:					
Allergies:							
Prescription							
Please indicate medication, dose, frequency, route, and length of therapy:							
Ancillary Orders							
·							
IV Flush Orders							
☐ <u>Periph</u>	Peripheral: NS 2 to 3 mL pre-/post-use. Heparin (10 unit/mL) 1 to 3 mL post-use. For maintenance, $\square$ NS 2 to 3 mL every 12 hr $\underline{or}$ $\square$ heparin (10 unit/mL) 1 to 3 mL						
		every 24 hr		iiil every 12 iii <u>or</u>		IIIL) I to 5 IIIL	
☐ Periph							
	Heparin (10 unit/mL) 3 mL post-use.						
				10 unit/mL) 3 mL (	every 12 hr $\underline{\mathit{or}}$ $\square$ (10	0 unit/mL) 3 mL	
		every 24 hr					
· · · · · · · · · · · · · · · · · · ·			ore-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw. (10 unit/mL) 5 mL <u>or</u> (100 unit/mL) post-use.				
For maintenance, heparin (10 unit/mL) 5 mL or (100 $\frac{O}{O}$							
☐ <u>Impla</u> ı	Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw.						
	Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to						
				) unit/mL) 3 to 5 n	nL every 24 hr if acce	ssed or weekly to	
□ Valved	Cathotors	monthly if not accessed.  NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw.					
□ <u>valved</u>	d Catheters:		For maintenance, NS 5 to 10 mL at least weekly.				
Lab Orders			,	,			
	s ordered at this time.						
	ssess and administer and/or teach sing support as needed. Refill above				ice as indicated abov	e. Nurse	
I cei	rtify that the use of the indicated tre	eatment is medi	cally necessary and	I will be supervisi	ng the patient's treat	tment.	
Prescriber Signature:					Date:		
Prescriber Information							
Prescriber Name:		Presum	Phone: Fax:				
Address:			NPI:				
City, State:		Zip:	Office Contact:				

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