



Patient Name: _____ DOB: _____
 Phone #: _____ Allergies _____

INFUSION SERVICES

Fax this form and a cover sheet to 920.623.6469 and call to schedule 920.623.6466
 On weekends call House Supervisor at 920.382.3913 or 920.623.3344

PRIOR AUTHORIZATION

Prior Authorization Completed Prior Auth # _____ Start Date _____ End Date _____
 Prior Authorization Not Required

MEDICATION

	Medication (name and dose)	Rate (i.e. per protocol)	Frequency (i.e. daily, weekly)	ICD 10 DX (# or diagnosis)	Ordered Start Date	Ordered End Date
#1						
#2						

LABS (frequency will be every Tuesday unless otherwise noted)

For renally eliminated medications, place order for creatinine if not performed in the past 7 days.

Serum Creatinine Level: _____ Date: _____

	Lab Test	Frequency	ICD 10 DX
#1			
#2			

Other Orders: _____

By signing this order form you agree to the following orders, unless otherwise noted.

- ✓ Place peripheral IV and maintain per hospital policy
- ✓ PICC or Central line maintenance per hospital policy
- ✓ Ordering provider will arrange placement of PICC line for infusions with a duration of 7 days or longer
- ✓ May initiate Cathflo protocol for occluded PICC/Central line followed by chest x-ray PRN for verification of placement
- ✓ Infusion/allergic reactions may be managed per facility protocol

Physician Name (print): _____ Physician Signature: _____
 Date: _____ Phone #: _____

If patient is acutely ill at the time of the planned service, they will be evaluated by the Prairie Ridge Health ER and their planned therapy may be canceled based on their condition. If patient declines an evaluation by our ER physician, the planned service will be canceled, and they will be asked to follow-up with the ordering provider.