Palmetto INFUSION

Phone: 1-800-809-1265 ext 105 Fax: 1-888-417-3658

MRN:_____

DOB: _____

Standard Plan of Treatment for Central Line Care/Peripheral IV Start

1. Patient Name:_____Height (inches):_____Weight (lbs):_____

2. Allergies: _____

3. Diagnosis:

Primary Diagnosis **ICD-10 Code:**_____**Diagnosis description:**_____

Secondary Diagnosis **ICD-10 Code:**_____**Diagnosis description:**_____

Orders: Assess catheter site every visit. Report any signs or symptoms of infection or other problems with site or line to the referring physician. Supplies needed to complete prescribed therapy. ***If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES.*** Utilize existing central line or initiate/utilize peripheral IV as needed for treatment of Adverse Reactions.

4. Drug(s):

☐ Sodium Chloride 0.9% IV flush 5-10 ml per line type as required.

☐ Heparin 100 units/ml IV flush 1-5 ml per line type as required

☐ Heparin 10 units/ml IV flush 1-5 ml per line type as required (for pediatric patients)

☐ Dispense _____ dose/doses ☐ Refills_____

5. Catheter Specific Orders:

☐ Peripheral IV Site: Initiate and/or change IV every 72-96 hours and as required per protocol

☐ Implanted venous ports: Access, flush, and de-access per protocol every 4 weeks

☐ External catheter lines (PICC, Hickman, Broviac, Groshong, Midline): Flush per protocol ☐daily ☐weekly or ☐ monthly. Change dressing and cap(s) every 5-7 days as per protocol.

Special orders: _____

Lab Orders: _____

6. Physician's Signature:_____/_____Date: _____

No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials: _____

7. Fax updated supporting clinical MD notes with each order renewal or change in orders

Infusion order forms available at www.palmettoinfusion.com

Revised 12/9/2021

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MRN: _____

DOB: _____

Guidelines for Prescribing Central Line Care/Peripheral IV Start

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:** _____

___ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-7)*
(Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)

___ Include patient demographic information and insurance information. (Copy of insurance cards if available)

___ **Supporting clinical MD notes to include rational for line type and/or treatment. Include any documentation on line type, device information, and/or procedure insertion note if available.**

___ Other as requested: _____
_____
_____

** **Warnings/Precautions:** Please counsel patient in risks, side effects, complications, and importance of compliance with care of peripheral IV or central line device. **Heparin Flush:** Hematologic side effects have included new thrombus formation in association with thrombocytopenia resulting from irreversible aggregation of platelets induced by heparin. Heparin sodium should not be used in patients: with hypersensitivity to heparin; with an uncontrollable active bleeding state, except when this is due to disseminated intravascular coagulation; with inability to perform suitable blood-coagulation tests, e.g., whole-blood clotting time, partial thromboplastin time, etc. at required intervals. There is usually no need to monitor effect of low-dose heparin in patients with normal coagulation parameters. See full prescribing information.

Palmetto Infusion Services will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.

Please fax all information to 1-88-417-3658 or call 1-800-809-1265 for assistance.

Revised 12/9/2021