

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

### Line Care Standard Plan of Treatment

#### PATIENT DEMOGRAPHICS:

Date of Referral:	Patient's Phone:
Patient Name:	Address:
Date of Birth:	City, State, Zip:
Height in inches:	Weight: LB or KG
Gender:	Allergies:
<input type="checkbox"/> See list	<input type="checkbox"/> NDKA

#### DIAGNOSIS: (PLEASE COMPLETE 2<sup>ND</sup> AND 3<sup>RD</sup> DIGITS TO COMPLETE ICD 10 FOR BILLING)

<input type="text"/>	- Other:
<input type="text"/>	- Other:

REQUESTED DOCUMENTATION:	PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?
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1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE	LAST INJECTION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INJECTION DATE:
4	Tried and failed therapies	FROM PREVIOUS	<b>IF ORDER CHANGE:</b> <input type="checkbox"/> <b>Continue current order until insurance approved</b>
5		THERAPY:	
6			

#### MEDICATION ORDERS:

##### CATHETER TYPE:

External catheter (PICC, Hickman, Broviac, Groshong, Midline)
  Implanted IV port
  Peripheral IV site  
 Multi-lumen catheter with \_\_\_\_\_ Lumens

##### MEDICATION:

Sodium Chloride 0.9% IV flush 5 - 10ml per line type as required.  
 Heparin 100 units/ml IV flush 1 - 5ml per line type as required  
 Heparin 10 units/ml IV flush 1 - 5ml per line type as required **(for pediatric patients)**

##### FREQUENCY:


Access, flush, and de-access per protocol every week  
 Access, flush, and de-access per protocol every 2 weeks  
 Access, flush, and de-access per protocol every 4 weeks  
 Other: \_\_\_\_\_

##### SPECIAL ORDERS:

\_\_\_\_\_

Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:	ADVERSE REACTION & ANAPHYLAXIS ORDERS:
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<input checked="" type="checkbox"/> Start PIV/Access CVC <input checked="" type="checkbox"/> Flush device per facility standard flushing procedure	Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here. 
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#### PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)	DATE
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<input type="text"/>	<input type="text"/>
Dispense as written/Brand medically necessary	Substitution permitted