

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

Rev 4.29.25

PATIENT DEMOGRAPHICS:

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

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

_____ - Other:
_____ - 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	IF ORDER CHANGE: <input type="checkbox"/> Continue current order until insurance approved
5		THERAPY:	
6			

MEDICATION ORDERS:

CATHETER TYPE:

External catheter (PICC, Hickman, Broviac, Groshong, Midline)
 Implants 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:

NURSING 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 <input checked="" type="checkbox"/> Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated	Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website.
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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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Dispense as written/Brand medically necessary	Substitution permitted