The Outpatient Infusion Center
a Service of Comanche County Memorial Hospital

Phone: 580-250-5899
Fax: 580-585-5472

GENERAL IV ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____
HT: _____ WT: _____ DOB: _____ Sex :( ) Male ( ) Female SSN:_____
Street Address_____ City/State/Zip _____
Home Phone # _____ Work # _____ Cell # _____

INSURANCE INFORMATION

Primary Insurance Name_____ Policy ID# _____
Secondary Insurance Name_____ Policy ID# _____

PHYSICIAN/FACILITY INFORMATION

Physician's Name_____ Contact Name _____ Contact Phone # _____
Address _____ City/State/Zip_____Fax #:_____
DEA# _____ NPI # _____ State License # _____

STATEMENT OF MEDICAL NECCESITY

Primary Diagnosis (ICD 10 code AND CPT code) _____
Secondary Diagnosis (ICD 10 code AND CPT code) _____

MEDICAL INFORMATION

Does the patient have venous access? ☐ Yes ☐ No If yes, what type? _____
Is the patient incontinent? ☐ Yes ☐ No Comments: _____
Is the patient ambulatory? ☐ Yes ☐ No Comments: _____

PRESCRIPTION ORDERS

50 mL BAG OF NORMAL SALINE WILL BE HUNG TO CLEAR ALL PATIENT LINES
***ALL MEDIPORTS/PORTS/VAD WILL BE FLUSHED WITH HEPARIN and SALINE PER HOSPITAL PROTOCOL**

FLUSHES:

☐ **10mL NS Flush Syringe PRN** ☐ **Heparin 500units/5mL Flush Syringe PRN** ☐ **10mL NS Flush Syringe PRN** ☐ **250mL NS PRN**

Labs, Meds, Other: _____

Physician's Signature _____Date _____ Time _____

☐ **DO NOT ADMINISTER HEPARIN TO THIS PATIENT**
UNLESS THE BOX IS CHECKED ALL PICC LINES, PORTS, MIDLINES, AND CENTRAL LINES MAY BE FLUSHED WITH HEPARIN AND SALINE PRN

Fax completed form to the Outpatient Infusion Center at 580-585-5472. PLEASE include copies of: H&P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, LETTER OF NECESSITY or any other documentation supporting the use of infusion therapy, and ALL current insurance information for your referral to be processed.