Maxor SPECIALTY PHARMACY

Infusion Physician Order Form

PATIENT INFORMATION

PATIENT NAME _____ DATE OF BIRTH _____

ORDERS

DX:

MEDICATIONS:

_____

_____

_____

_____

_____

_____

_____

_____

STOP DATE: _____

LAB ORDERS:

○ CBC ○ ESR/CRP ○ VANCOMYCIN TROUGH - TO BE DRAWN IMMEDIATELY PRIOR TO VANC INFUSION

○ CMP ○ CK ○ OTHER: _____

LAB FREQUENCY:

○ WEEKLY ○ OTHER: _____

LINE TYPE:

Type: _____ #LUMENS: _____

○ CVC DRESSING CHANGE WEEKLY OR: _____

FLUSHING INSTRUCTIONS:

○ SODIUM CHLORIDE 0.9%-10 ML; FLUSH IV CATHETER WITH 5 ML TO 10 ML AS DIRECTED

○ HEPARIN 100 ML/5 ML - FLUSH IV CATHETER WITH 3 ML TO 5 ML AS DIRECTED

○ OTHER: _____

HOME HEALTHCARE AGENCY:

PHONE:

FAX:

PRESCRIBER / DEA NUMBER / NPI:

PHYSICIAN SIGNATURE _____ DATE _____

PHARMACY INFORMATION

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