Southwestern Medical Center
Empowered by ScionHealth
Phone: 580-531-4892
Fax: 877-249-1191

SOUTHWESTERN MEDICAL CENTER INFUSION SERVICES
GENERAL IV ORDER FORM

☐ **STAT REFERRAL**

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____ DOB:_____

HT: _____ in WT: _____ kg Sex :( ) Male ( ) Female Allergies: ( ) NKDA, _____

_____

Physician Name_____ Contact Name _____ Contact Phone # _____

NPI #:_____ Tax ID#:_____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD 10 CODE + DESCRIPTION) Secondary Diagnosis: (ICD 10 CODE + DESCRIPTION)

_____ _____

Does patient have venous access? ☐ **YES** ☐ **NO** **If yes, what type** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

PRESCRIPTION ORDERS

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH HEPARIN OR SALINE PER HOSPITAL PROTOCOL PRN
b) BIOSIMILAR EQUIVILENT SUBSTITUTION MAY APPLY

PLEASE SELECT FROM BELOW:

_____ Perform port flush every _____ weeks per hospital protocol.
_____ Perform IV site care per hospital protocol.
_____ Activase 2mg IVP per hospital protocol.

NOTE: For patients with central venous access, please select: ☐ **D/C AFTER LAST DOSE**

DRUG 1	**DOSE**	**ROUTE**	**FREQUENCY**	**DURATION**
DRUG 2	**DOSE**	**ROUTE**	**FREQUENCY**	**DURATION**
DRUG 3	**DOSE**	**ROUTE**	**FREQUENCY**	**DURATION**
DRUG 4	**DOSE**	**ROUTE**	**FREQUENCY**	**DURATION**

LABS

SELECT BELOW	LAB REQUESTED	FREQUENCY
	NONE	**NA**
	CBC w/ Diff	
	BMP	
	CMP	
	BUN/CREATININE	
	ESR	
	CRP	
	CPK	
	Other:	
	Other:	

NOTES/INSTRUCTIONS/OTHER

_____
_____
_____
_____
_____
_____
_____
_____
_____

Physician's Signature _____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

Cosignature (If Required)_____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.