RESET

INFUSE ALASKA
Solutions at Home

INFUSION THERAPY ORDER

Infuse Alaska
6250 Tuttle Place St 7 Anchorage, AK. 99507
Phone: (907) 222-9979 Fax: (888) 728-0205

PATIENT INFORMATION

Patient Name: **Date of Birth:** ☐ M ☐ F

Address: Phone:_____ HT: _____WT: _____

DX (ICD-10 code):

Allergies:

MEDICATION

_____

DRUG **DOSE** **RATE** **ROUTE** **FREQUENCY** **#OF DOSES / DURATION**

Has patient received this drug before? Y / N **Next dose due:** _____(date, time)

☐ Rate, dilution, and administration per Infuse AK protocol, unless otherwise specified.

☐ First dose precautions per Infuse AK protocol (first dose to be given in Infuse AK Infusion suite)

LINE CARE

Access Type (PICC, Hickman, Groshong, Port, Peripheral): _____
Number of Lumens: ☐ 1 ☐ 2 ☐ 3

☐ IV access flushing with Normal Saline and Heparin 10u/ml or 100u/ml per Infuse AK protocol, unless otherwise specified. Dispense PRN. (☐ Do not use heparin flushes)
☐ CADD Ambulatory pump or Elastomeric Infusion device as appropriate
☐ Alcohol prep pads, chemo spill kit, disinfecting caps, dressing change kits – to dispense PRN
☐ IV Start Kit ☐ CADD Tubing ☐ Rate Flow Tubing ☐ Other:_____
☐ Alteplase 2mg/2ml for line declotting PRN, QTY: 1, Refill: PRN

NURSING / LABS

☐ **Infuse Alaska Skilled Nursing** to access line, infuse medications, monitor therapy, perform PRN assessment, perform teaching , perform dressing changes weekly and PRN, and draw labs as ordered.

Or ☐ Other Home Health Agency (_____)to draw labs and maintain line

☐ **Laboratory Orders:** _____

☐ CBC ☐ CBC with diff ☐ CMP ☐ CRP ☐ ESR ☐ Vanco trough as indicated
Other _____
☐ Labs to be drawn weekly, or _____ (frequency)
☐ Send lab results to: _____ Fax#: _____

F/U

Follow-up appointment with _____(MD) on _____ (date).

_____ _____ _____
Prescriber's Name Prescriber's Signature Date

NPI _____ Phone # _____ Fax#_____

Fax the following to Infuse Alaska Pharmacy at **888-728-0205:**

[1]*Completed order*, [2]*Demos*, [3]*Insurance*, [4]*Clinical Notes (*H&P, progress), [5]*Line placement confirmation* by CXR [6] *Lab results and CMN if applicable*