

GENERIC PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to: (603) 696-3577

Patient Name: _____		Date of Birth: _____	
Address: _____			
Phone: _____	Height: ☐ inches ☐ cm	Weight: ☐ lbs ☐ kg	
Order(s)			
PRIMARY DIAGNOSTIC DESCRIPTION: _____		ICD-10 CODE: _____	
ALLERGIES: _____			
MEDICATION ORDER			
Drug	Route	Dose	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
LINE TYPE (select one) ☐ PICC # Lumens _____ ☐ Midline ☐ Central line ☐ Port Port Needle Size _____			
0.9% Sodium Chloride flush IV catheter with 5 - 10 mL before and after each dose, daily when not in use. Flush pre/post lab draw with 5 - 10 mL Dispense up to quantity #90 with refill x 12			
PLEASE CHOOSE ONE BELOW: ☐ Heparin 10 units/mL flush IV catheter with 3 - 5 mL after second saline flush, daily when not in use. Dispense up to quantity #90 with refill x 12 ☐ Heparin 100 units/mL flush IV catheter with 3 - 5 mL after second saline flush, daily when not in use. Dispense up to quantity #90 with refill x 12 ☐ No Heparin			
PLEASE SELECT CATHFLO IF INDICATED: ☐ Alteplase (Cathflo) 2mg per lumen to dwell, may dispense and repeat x1 per incident of sluggish/occluded line. Qty#2 Pharmacy to dispense flushes and IV catheter supplies until catheter removed or de-accessed. Dispense all medically necessary supplies for the length of therapy. Refill above ancillary orders as directed x 1 year.			
LAB ORDERS (Select all required) Lab start date: _____ Frequency: _____ ☐ CBC with Diff ☐ BMP ☐ CMP ☐ CPK ☐ ESR ☐ CRP ☐ Liver Panel ☐ BUN ☐ SCr ☐ Vancomycin trough (target trough level) _____ Frequency _____ Start date _____ ☐ Gentamicin ☐ Tobramycin ☐ Amikacin through peak (target levels) _____ Frequency _____ Indicate additional labs: _____ Report lab results/following physician Name: _____ Phone: _____ Fax: _____ <i>I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.</i> Prescriber Signature: _____ Date: _____			
Prescriber Information			
Prescriber Name: _____		Phone: _____	Fax: _____
Address: _____		NPI: _____	
City, State: _____	Zip: _____	Office Contact: _____	

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or that do not require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws.

IMPORTANT WARNING: This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately. Brand names are the property of their respective owners.

REFERRAL REQUIREMENTS: To facilitate timely review and scheduling, this order form must be accompanied by the patient's most recent office/progress notes, all pertinent laboratory results (including culture reports when applicable), and a copy of the front and back of the patient's insurance card. Incomplete referrals may result in delays in processing and treatment.