NORTHEAST
MEDICAL INFUSION CENTER

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	End Date

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 certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: _____ Date: _____

Prescriber Information

Prescriber Name:		Phone:	Fax:
Address:		NPI:	
City, State:	Zip:	Office Contact:	

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.