

# Infusion Therapy

Please call (800) 940-5151 before faxing to ensure delivery.

Fax: (800) 676-3127

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PLEASE ATTACH DEMOGRAPHICS AND SUBSCRIBER'S INSURANCE CARD/INFORMATION.

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Patient Name: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Surgical Procedure: \_\_\_\_\_

Ordering Physician: \_\_\_\_\_

Phone: (     ) \_\_\_\_\_

## Type of Medication/Dose/Frequency:

Rx: \_\_\_\_\_

Duration Rx: \_\_\_\_\_

Next Dose Due: \_\_\_\_\_

*Please attach a specific Rx for TPN Formula.*

Allergies: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

HHC to insert PIV or Midline

Type of Line:  PICC  Groshong  PIV  Port  Other: \_\_\_\_\_

Number of Lumens: \_\_\_\_\_

Has the patient had this IV medication before?  Yes  No

If no, please order ANA kit.

Labs Ordered: \_\_\_\_\_

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Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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