



Pharmacy Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

Email: _____

Patient Information

Patient Name		Parent/Guardian Name (if applicable)	All Insurance Info Attached	
Address		City State Zip		
Main Phone	Alternate Phone	Email		
Date of Birth	Male Female	Weight (required)	kg lbs	Height (required) ft in
Allergies	Diabetic: No Yes			

Medical Information

Primary Diagnosis	ICD-10 Code
Home Health Agency	

Prescription and Orders

Medication	Dose	Frequency	Duration
Medication	Dose	Frequency	Duration
Medication	Dose	Frequency	Duration

Pharmacy to dose based on current lab results? No Yes

1. IV Access:

_____ PICC Lines:

Weekly dressing changes unless integrity of dressing changes or becomes soiled. Securing device to be used unless line is sutured in. Flush with 10mL NS before and after each use and weekly when not in use. If administering TPN or drawing labs flush with 20mL NS after use. May use 5mL Heparin flush 100 unit/mL for sluggish line. Use only 10mL syringe or larger.

_____ Midline Catheter:

Weekly dressing changes unless integrity of dressing changes or becomes soiled. Securing device to be used unless line is sutured in. Flush with 10mL NS before and after each use and weekly when not in use. If administering TPN or drawing labs flush with 20mL NS after use. May use 5mL Heparin flush 100 unit/mL for sluggish line. Use only 10mL syringe or larger.

_____ Peripheral IV:

Dressing change at site rotation every 72-96 hours or when clinically indicated. Flush with 5-10mL NS before and after each use. May use 3mL Heparin flush 10 unit/mL. Other:

2. Anaphylaxis Protocol:

Epinephrine 0.3mg IM / Diphenhydramine 25-50mg by mouth PRN.

3. Labs Needed:

Frequency of Labs: _____ or Labs Per Pharmacy Protocol

4. Pull IV access when therapy is complete.

5. May discharge patient when therapy is complete.

Physician Information

Physician Name	DEA #	NPI #	License #
Address		City State Zip	
Phone	Fax	Office Contact	

I authorize Vital Care Infusion Services LLC and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Vital Care.

Physician Signature: _____

Date: _____

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

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