

### 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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This form is not considered an order or prescription for medical services and/or supplies unless and until it is formally authorized by a healthcare provider in compliance with applicable laws and regulations.