SHERIDAN COMMUNITY HOSPITAL
OUTPATIENT INFUSION CENTER
PHONE: 989.291.6295 FAX: 877.249.1191

☐ **STAT REFERRAL**

GENERAL IV ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI____ DOB:_____

HT: _____ in WT: _____ ☐ lbs ☐ kg Sex: ☐ Male ☐ Female Allergies: ☐ NKDA, _____

_____

Physician Name_____ Contact Name _____ Contact Phone # _____

NPI #:_____ Tax ID#:_____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD 10 CODE + DESCRIPTION)

_____

Secondary Diagnosis: (ICD 10 CODE + DESCRIPTION)

_____

Does patient have venous access? ☐ **YES** ☐ **NO** **If yes, what type** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**_____

PRESCRIPTION ORDERS

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH HEPARIN OR SALINE PER HOSPITAL POLICY PRN

b) 500 mL BAG OF 0.9% NS MAY BE HUNG AT KVO RATE

PLEASE SELECT FROM BELOW:

☐ Perform port flush every _____ weeks per hospital policy.
☐ Perform IV site care per hospital policy.

NOTE: For patients with central venous access, please select: ☐ **D/C AFTER LAST DOSE**

DRUG 1	**DOSE**	**ROUTE**	**FREQUENCY**	**DURATION**
DRUG 2	**DOSE**	**ROUTE**	**FREQUENCY**	**DURATION**
DRUG 3	**DOSE**	**ROUTE**	**FREQUENCY**	**DURATION**
DRUG 4	**DOSE**	**ROUTE**	**FREQUENCY**	**DURATION**

LABS

SELECT	LAB REQUESTED	FREQUENCY
☐	**NONE**	**NA**
☐	**CBC w/ Diff**	
☐	**BMP**	
☐	**CMP**	
☐	**BUN/CREATININE**	
☐	**ESR**	
☐	**CRP**	
☐	**CPK**	
☐	**Other:**	
☐	**Other:**	

NOTES/INSTRUCTIONS/OTHER

Physician's Signature _____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

Cosignature (If Required)_____ **Time**_____ **Date**_____
**Signature Must Be Clear and Legible*

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.