FirstHealth OF THE CAROLINAS

OP Custom Infusion Builder With Additives Referral

3POREF001

Place Patient Label Inside This Box

***** This section refers to the entire plan. If individual orders need a different interval, please indicate in each section below*****

Version 6/2021

Date of Infusion: _____

Patient Name: _____

Patient SSN (if available): _____

Insurance Name: _____

Secondary Insurance: _____

Diagnosis Code: _____

Diagnosis Code Description: _____

Lead Physician _____

Date of Birth: _____

Contact Number: _____

Policy Number: _____

Policy Number: _____

Precertification: ☐ Initiated ☐ Complete

Location to be Performed:

☐ Moore Regional Hospital (MRH)

☐ Montgomery Memorial Hospital (MMH)

Interval _____ Day _____ of every _____ month

Minimum Separation _____ days / weeks (circle one)

Next Due Date _____

Duration: ☐ Until discontinued ☐ ____ Treatments ☐ Until _____

Nursing Orders	**Interval**	**Duration**
☐ Insert peripheral IV Once	_____	_____
Picc Access And Flush Orders		
☐ PICC Line Access Once	_____	_____
☐ Heparin, porcine (PF) 10 unit/mL injection 50 Units 50 Units, intravenous Once	_____	_____
Vascular Access Device (cvc) Access and Flush Orders		
☐ Central Venous Catheter (CVC) access Once	_____	_____
☐ Heparin, porcine (PF) injection 500 units, IV once	_____	_____
Medications		
☐ Custom IV infusion builder intravenous, Once	_____	_____
☐ RATE _____ml/hr	_____	_____
Additives		
☐ adult MVI with vit K _____ ml	_____	_____
☐ potassium chloride ☐ 20 meq ☐ 40 meq	_____	_____
☐ thiamine _____ mg	_____	_____
☐ folic acid _____ mg	_____	_____
☐ magnesium sulfate ☐ 1g ☐ 2g	_____	_____

Provider Signature: _____ **Date:** _____ **Time:** _____

* May be used as EPIC Downtime Form

Place Patient Label
Inside This Box

Additives (continued)	Interval	Duration
☐ calcium gluconate ☐ 1g ☐ 2g	_____	_____
☐ sodium bicarbonate ☐ 50 meq ☐ 100meq ☐ 150meq	_____	_____
☐ promethazine ☐ 12.5mg ☐ 25mg ☐ 50mg	_____	_____
☐ heparin 1,000unit/ml _____	_____	_____
Base		
☐ 500ml ☐ 1000ml	_____	_____
☐ Dextrose 5%	_____	_____
☐ Dextrose 10%	_____	_____
☐ D5% and 0.2% sodium chloride	_____	_____
☐ D5% and 0.45% sodium chloride	_____	_____
☐ D5% and 0.9% sodium chloride	_____	_____
☐ D2.5% and 0.45% sodium chloride	_____	_____
☐ sodium chloride 0.9%	_____	_____
☐ sodium chloride 0.45%	_____	_____
☐ lactated ringers	_____	_____
☐ sterile wate	_____	_____

For Scheduling Fax Forms to: (910) 715-1177.

Provider Signature: _____ Date: _____ Time: _____

* May be used as EPIC Downtime Form