FirstHealth
OF THE CAROLINAS

7096.08.16144.01 Sunset Date: 6/2024

OP Heparin Flush For Vad And PICC Referral

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: ______________________
Lead Physician ______________________
Patient Name: ______________________
Date of Birth: ______________________
Patient SSN (if available): ______________________
Contact Number: ______________________
Insurance Name: ______________________
Policy Number: ______________________
Secondary Insurance: ______________________
Policy Number: ______________________
Diagnosis Code: ______________________
Precertification: ☐ Initiated ☐ Complete
Diagnosis Code Description: ______________________
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 ______________________

Picc Access And Flush Orders	**Interval**	**Duration**
☐ 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 500 Units, intravenous, Once	________	________

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

Provider Signature: ______________________ **Date:** ____________ **Time:** ____________

* May be used as EPIC Downtime Form