Heart of the Rockies Regional Medical Center Infusion Center Order Form

Authorizations and Centralized Scheduling: (f) 719-530-2201 (p) 719-530-2396
For help completing medication orders call the main pharmacy: (p) 719-530-2207
Patient Name: _____ DOB: _____

THIS FORM MUST BE PRINTED AFTER COMPLETION AND THE FINAL ORDER PAGE MUST BE SIGNED AND DATED BY THE ORDERING PROVIDER. FAX SIGNED ORDER TO HRRMC CENTRALIZED SCHEDULING 719-530-2201

Patient & Provider Demographics

Patient Name (Last, First): _____

DOB: _____ Patient Phone Number: _____

Patient Address: _____

Primary Insurance: _____ Secondary Insurance: _____

Known Drug Allergies: _____

Diagnosis for Infusion Treatment: _____

ICD10 Code: _____ Date of Diagnosis: _____

Height (cm): _____ Weight (kg): _____

BSA: _____

Practice Name: _____

Practice Address: _____

Practice Phone: _____ Practice Fax: _____

Provider Name: _____ Provider TaxID: _____

Provider NPI: _____ Provider DEA (if controls are ordered): _____

Last page of Orders: ☐ Page 2 ☐ Page 3 ☐ Page 4

Labs:

☐ CBC Frequency: _____

☐ BMP Frequency: _____

☐ Other (include frequency): _____

Parameters to Treat:

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Pre-medications and/or IV Hydration

Medication Name:	Medication Name:
Route: ☐IV ☐SQ ☐IM	Route: ☐IV ☐SQ ☐IM
Dose:	Dose:
Diluent:	Diluent:
Volume:	Volume:
☐Rate (specify units/time): ________________________.	☐Rate (specify units/time): ________________________.
Timing of pre-medication:	Timing of pre-medication:
Frequency of Dose:	Frequency of Dose:

Medication Name:	Medication Name:
Route: ☐IV ☐SQ ☐IM	Route: ☐IV ☐SQ ☐IM
Dose:	Dose:
Diluent:	Diluent:
Volume:	Volume:
☐Rate (specify units/time): ________________________.	☐Rate (specify units/time): ________________________.
Timing of pre-medication:	Timing of pre-medication:
Frequency of Dose:	Frequency of Dose:

Medication Name:	Medication Name:
Route: ☐IV ☐SQ ☐IM	Route: ☐IV ☐SQ ☐IM
Dose:	Dose:
Diluent:	Diluent:
Volume:	Volume:
☐Rate (specify units/time): ________________________.	☐Rate (specify units/time): ________________________.
Timing of pre-medication:	Timing of pre-medication:
Frequency of Dose:	Frequency of Dose:

☐Sodium Chloride 0.9% at ________ mL/hr total volume to be infused: ☐250mL ☐500mL ☐1000mL

Administer ☐before ☐during ☐after infusion

☐Dextrose 5% at ________ mL/hr total volume to be infused: ☐250mL ☐500mL ☐1000mL

Administer ☐before ☐during ☐after infusion

☐Other ________________ at ________ mL/hr total volume to be infused: ☐250mL ☐500mL ☐1000mL

Administer ☐before ☐during ☐after infusion

Other:

Ordering Provider Signature: ____ Order Date: ____________________

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Infusion Treatment Plan

☐ HRRMC Adult Hypersensitivity/Infusion Reaction Protocol and Algorithm

Medication Name:	Medication Name:
Route: ☐IV ☐SQ ☐IM	Route: ☐IV ☐SQ ☐IM
☐Brand Name Medically Necessary	☐Brand Name Medically Necessary
DAW1 Necessary Brand Name:	DAW1 Necessary Brand Name:
Dose:	Dose:
Diluent:	Diluent:
Final Volume: ☐50 mL ☐100 mL ☐150 mL ☐250mL ☐500mL ☐1000mL ☐other:	Final Volume: ☐50 mL ☐100 mL ☐150 mL ☐250mL ☐500mL ☐1000mL ☐other:
☐Rate (specify units/time): _____. ☐HRRMC Infusion Titration & Fluids Protocol	☐Rate (specify units/time): _____. ☐HRRMC Infusion Titration & Fluids Protocol
☐Custom Titration Protocol:	☐Custom Titration Protocol:
Frequency of Dose & Cycle Schedule:	Frequency of Dose & Cycle Schedule:
Duration of Treatment:	Duration of Treatment:
Sequence in Plan Administration:	Sequence in Plan Administration:

Medication Name:	Medication Name:
Route: ☐IV ☐SQ ☐IM	Route: ☐IV ☐SQ ☐IM
☐Brand Name Medically Necessary	☐Brand Name Medically Necessary
DAW1 Necessary Brand Name:	DAW1 Necessary Brand Name:
Dose:	Dose:
Diluent:	Diluent:
Final Volume: ☐50 mL ☐100 mL ☐150 mL ☐250mL ☐500mL ☐1000mL ☐other:	Final Volume: ☐50 mL ☐100 mL ☐150 mL ☐250mL ☐500mL ☐1000mL ☐other:
☐Rate (specify units/time): _____. ☐HRRMC Infusion Titration & Fluids Protocol	☐Rate (specify units/time): _____. ☐HRRMC Infusion Titration & Fluids Protocol
☐Custom Titration Protocol:	☐Custom Titration Protocol:
Frequency of Dose & Cycle Schedule:	Frequency of Dose & Cycle Schedule:
Duration of Treatment:	Duration of Treatment:
Sequence in Plan Administration:	Sequence in Plan Administration:

Ordering Provider Signature: _____ Order Date: _____

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Infusion Treatment Plan Continued

☐HRRMC Adult Hypersensitivity/Infusion Reaction Protocol and Algorithm

Medication Name:	Medication Name:
Route: ☐IV ☐SQ ☐IM	Route: ☐IV ☐SQ ☐IM
☐Brand Name Medically Necessary	☐Brand Name Medically Necessary
DAW1 Necessary Brand Name:	DAW1 Necessary Brand Name:
Dose:	Dose:
Diluent:	Diluent:
Final Volume: ☐50 mL ☐100 mL ☐150 mL ☐250mL ☐500mL ☐1000mL ☐other:	Final Volume: ☐50 mL ☐100 mL ☐150 mL ☐250mL ☐500mL ☐1000mL ☐other:
☐Rate (specify units/time): _____. ☐HRRMC Infusion Titration & Fluids Protocol	☐Rate (specify units/time): _____. ☐HRRMC Infusion Titration & Fluids Protocol
☐Custom Titration Protocol:	☐Custom Titration Protocol:
Frequency of Dose & Cycle Schedule:	Frequency of Dose & Cycle Schedule:
Duration of Treatment:	Duration of Treatment:
Sequence in Plan Administration:	Sequence in Plan Administration:

Medication Name:	Medication Name:
Route: ☐IV ☐SQ ☐IM	Route: ☐IV ☐SQ ☐IM
☐Brand Name Medically Necessary	☐Brand Name Medically Necessary
DAW1 Necessary Brand Name:	DAW1 Necessary Brand Name:
Dose:	Dose:
Diluent:	Diluent:
Final Volume: ☐50 mL ☐100 mL ☐150 mL ☐250mL ☐500mL ☐1000mL ☐other:	Final Volume: ☐50 mL ☐100 mL ☐150 mL ☐250mL ☐500mL ☐1000mL ☐other:
☐Rate (specify units/time): _____. ☐HRRMC Infusion Titration & Fluids Protocol	☐Rate (specify units/time): _____. ☐HRRMC Infusion Titration & Fluids Protocol
☐Custom Titration Protocol:	☐Custom Titration Protocol:
Frequency of Dose & Cycle Schedule:	Frequency of Dose & Cycle Schedule:
Duration of Treatment:	Duration of Treatment:
Sequence in Plan Administration:	Sequence in Plan Administration:

Ordering Provider Signature: _____ Order Date: _____