

FAX

To: Upstate HomeCare Intake

Fax#: (315) 580-4297

Patient Name:

Date of Birth:

Diagnosis:

Allergies:

Therapy Ordered

Drug:

Dose:

Frequency:

Modality: IV SQ IM

In-Home Start Date:

Stop Date:

Flushing

Sodium Chloride 10ml Flushes
For IV, flush before & after each
infusion
#100 with 11 refills

Heparin 5 ml Lock 100 u/ml
For IV, flush after infusion
#100 with 11 refills

Heparin 5 ml Lock 10 u/ml
For IV, flush after infusion
#100 with 11 refills

Labs

CBC w/differential

CMP

CRP

ESR

Other: _____

Labs due weekly while on therapy

Trough prior to _____ dose on _____ ; then weekly on _____

Forward Results to: _____

Ordering Provider:

NPI#:

Provider Signature:

Date:

By signing this form, you, as the following physician are authorizing an Upstate HomeCare Pharmacist to transcribe the above order into verbal orders.

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