Upstate HomeCare

The Best for Getting Better

INFUSION PRESCRIPTION FORM

Phone: (877) 286-0800
Fax: (315) 580-4297

Complete or Attach Patient's Demographic Information

Patient Name: _____ Gender: _____ DOB: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Preferred Phone: _____ Alternate Phone: _____
Email Address: _____

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

Anaphylactic Orders:

☐ Epinephrine 1mg/mL Vial #1 (Use in the event of an anaphylactic reaction. Adult dose = 0.3mL **IM**/intramuscularly)

Labs

☐ CBC w/differential ☐ CMP ☐ CRP ☐ ESR ☐ Vancomycin Trough

☐ Other: _____

☐ Labs due weekly while on therapy

☐ Forward Results to: _____

Complete Prescriber Information

Ordering Provider: **Phone:**

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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