



HISTORY & PHYSICAL PHYSICIAN ORDERS Infusion Center

Call to schedule appointment (517)364-5510, fax # (517)364-5511.

Patient name: _____ Ht.: _____ Wt.: _____ BSA: _____ Pain: _____ DOB: _____

History: _____ yr/old _____ (M/F) in _____ general health, with a diagnosis of _____

sent to the Intravenous Specialty Infusion Center for _____ .

Indications for treatment: _____

Allergies: _____ Bleeding tendency: _____

Medications: _____

Previous surgeries/illness: _____

Gynecology/obstetrical patients: gravida _____ para _____ LMP _____

Physical Examination: temp: _____ pulse: _____ resp.: _____ blood pressure: _____ pain: _____

Pertinent examination: _____

Neuro: _____ HEENT: _____ C/V: _____ Lungs: _____ GI: _____

GU: _____ Skin: _____ Extremities: _____ Other: _____

Pertinent x-ray findings: _____

Pertinent laboratory findings: _____

| Date | Time | Orders | |
|------|------|---|--|
| | | Start peripheral access device: <input type="checkbox"/> Yes <input type="checkbox"/> No Start PICC line: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | Use existing central venous access for laboratory draws: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | Use existing central venous access for medication delivery <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | Laboratory orders: | |
| | | Premeds: | |
| | | | |
| | | | |
| | | Medications: | |
| | | | |
| | | Initiate anaphylaxis protocol if needed. | |
| | | Consult Pharmacy Dosing Service. | |
| | | Diet: _____ Activity: _____ | |
| | | Heparin flush peripheral: <input type="checkbox"/> pediatric 10 units/ml (1ml) <input type="checkbox"/> adult 100 units/ml (1ml) | |
| | | D/C peripheral device after medication complete: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | <input type="checkbox"/> Heparin flush central line 100 units/ml (2.5 ml) <input type="checkbox"/> I/P 100 units/ml (5 ml) | |
| | | Discharge to home when vital signs stable. | |
| | | Follow-up office appointment scheduled: date _____ time _____ | |

**Orders must be renewed
the first of every month.**

Authorization is granted to supply by non-proprietary name as per formulary policy unless checked here.

| | |
|--|----------------------------------|
| Doctor X | Reg. No. |
| Verbal/Telephone orders read back <input type="checkbox"/> yes | Date _____ Time _____ |
| Noted By X | R.N. _____ Date _____ Time _____ |