REFERRAL SOURCE/HOSPITAL: _____

DISCHARGE PLANNER/ PHONE NO. _____

HOSPICE TELEPHONE ORDER INFUSION THERAPY

RPh, complete and attached any signed chart orders, current labs, history and physical, then fax to approved pharmacy vendor

FAX (888) 395-9798

Patient Name: DOB: MRN:

Address: City, State, Zip:

Allergy Hx:

Agency Name: Diagnosis

RN/Caregiver Name(s): Phone

	Primary Dx:	Secondary Dx:	Height:	Weight:
DELIVERY	STAT ORDER	ROUTINE DELIVERY	OVERNIGHT SHIPPING	DATE/TIME
IV ACCESS: KIT & SUPPLIES		**PERIPHERAL:** Access Cathe Needle, Tubing Primary/CADD 0.2µ, IV Starter Kit, Alcohol Swabs, NS 0.9% SYR, Cover Band, Flush, IV Pole Disposable.		**SUBQ/IM:** Access SubQ Needle, Alcohol Swab, IV Starter Kit, Alcohol Swabs, Gloves, Tegaderm, Adhesive Remover, Tubing Primary/CADD 0.2µ, Cover Band, IV Pole Disposable
		CENTRAL PICC: Central Line Change Kit X1, CADD 0.2µ Tubing, Tegaderm, Microclave Connector/Extension, Tegaderm, Statlock, Alcohol Swabs, Gloves, Povidine Stick/Swab, Curos Caps (3/Bag), NS 0.9% SYR Flush, Cover Band, IV Pole Disposable.		**CENTRAL PORT-A-CATH**: Central Dressing Kit, Access needle Microclave Connector/Extension, Tubing Primary/CADD 0.2µ, Tegaderm, Statlock, Alcohol Swabs, Gloves, Povidine Stick/Swab, Curos Caps (3/Bag), NS 0.9% SYR Flush, Cover Band, IV Pole Disposable.
ANTICOAGULATION		Heparin 100iu/ml IV Flush SYR		Cathflo® (alteplase)
ADD'LSUPPLIES		Alcohol Swabs		BD SAF-T-INTIMA SubQ Needle 24GX0.75IN
		IV Starter Kit (peripheral		SubQ needle infusion set or equivalent
		Dial-A-Flow Tubing		Kawasumi butterfly needles
		INSYTE Autoguard 22G x 1IN		Adhesive Remover Pad
		Anaphylactic Kits		

INFUSION THERAPY (CHECK one or more therapies below). HANDWRITTEN RX IS REQUIRED FOR C-II *(circle one)*

	Morphine 5mg/ml NS 0.9% IV	100mL	250ml		Morphine 10 mg/ml NS 0.9% IV	100mL	250ml
	Morphine 25mg/ml NS 0.9% IV	100mL	250ml		HydroMORPHONE 0.2mg/ml NS 0.9% IV	100mL	250ml
	HydroMORPHONE 1mg/ml NS 0.9% IV	100mL	250ml		HydroMORPHONE 5mg/ml NS 0.9% IV	100mL	250ml
	HydroMORPHONE 10mg/ml NS 0.9% IV	100mL	250ml		Lorazepam 1 mg/ml NS 0.9% IV	100mL	
	Midazolam 1mg/ml NS 0.9% IV	100mL			Ketamine 2mg/ml NS 0.9% IV	100mL	
					Fentanyl 50 *MCG*/ml NS 0.9% IV	100mL	

hand-write order(s) in this space

℞

PCA SETTINGS:

Cont. Basal Rate: _____mg/hr

Demand Dose: _____mg

Lock-Out Interval: _____min.

Max Dose Limit : _____mg/hr (optional)

RPh Notes

S CODE	PERDIEM	QTY
S		
S		
S		
S		
S		

Notes:

TOV/RB:

Signature: _____ Prescriber: _____

NPI: _____ DEA: _____ Date: _____

Substitution Permissible- in order for a brand name product to be dispensed, the prescriber must hand write "brand medically necessary" in the space. Non-child resistant packaging will be used unless prescriber indicates otherwise.

Exemption HSC 11167.5 (C-II)

ORDER VERIFIED WITH PRESCRIBER

Verbal order taken and read back by: _____ RPH # _____ Date: _____

2895 Temple Ave
Signal Hill, CA 90755
Phone: 888.881.9924
Fax: 844.888.0765

345 Convention Way, Suite C
Redwood City, CA 90755
Phone: 888.999.0991
Fax: 888.395.9798

HOSPICE SCHEDULE II TELEPHONE ORDER FORM

AGENCY NAME:

Patient ID:_____
Primary Hospice Diagnosis:_____
Allergy: _____

□ Same Day □ Next Day □ Other Date:_____
Time Order:_____**Time Expected:**_____

□ **Dr.**

Patient Name DOB	Caregiver/Team
Address	Caregiver Phone
City **CA** ZIP	**Pickup by:** _____
Allergy	Date: _____
	Signature: _____

MEDICATION ORDER:

Drug:_____**QTY:**_____

Sig:_____

_____

_____

_____

Substitution Permissible- in order for a brand name product to be dispensed, the prescriber must hand circle the "brand medically necessary" in the space. Non-child resistant packaging will be used unless prescriber indicates otherwise

Exemption HSC 11167.5

ORDER VERIFIED WITH PRESCRIBER

Veral order taken and read back by:_____RPH **License #**:_____

Signature: _____ **Date**: _____