

Infusion

Implanted Port Care Orders



PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip Code: _____
Emergency Contact: _____ Relationship: _____ Phone: _____

PROVIDER INFORMATION

Referring provider: _____ Phone: _____ Fax: _____

INSURANCE

The following information is required to obtain insurance authorization. Information not provided will cause a delay in treatment. Patient is uninsured.

1. Copy of current insurance card. 2. Copy of demographics sheet 3. Copy of most recent OV note and labs

PRIMARY DIAGNOSIS: Provide ICD-10 code and description

Provide ICD-10 code and description: _____

Weight: _____ Height: _____ Allergies: _____

Is the patient ambulatory? Yes No Does the patient require bariatric equipment? Yes No

ORDERS

- Access/Deaccess Implanted Port for treatment per Salem Health CVAD Access Policy. Follow routine CVAD catheter care per manufacture device maintenance card if card is available.
- Alteplase per Salem Health Central Venous Access Device declotting (*Lippincott*) for S/sx of occlusion: Inability to infuse fluids, no blood return, increased resistance when flushing, increased occlusion/high-pressure alarm when using an infusion pump, sluggish gravity flow.
- 1 View Chest X-ray to verify catheter tip location PRN for: Catheter migration greater than 5 cm, signs and symptoms of tip malposition (*occlusion unresolved by Alteplase, discomfort in the arm, neck or chest, unusual sensations or sounds when flushing, neck vein engorgement, or heart palpitations.*) Notify Physician or Provider

Additional Orders:

1. _____
2. _____
3. _____

Provider Signature

Provider Printed Name

Date: