Infusion

Chest CVAD (Groshong)

Salem Health® Hospitals & Clinics

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **MI:** ____ **DOB:** _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

PROVIDER INFORMATION

Referring Provider: _____ Phone Number: _____ Fax Number: _____

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: _____

Weight: _____ **Height:** _____ **Allergies:** _____

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

ORDERS

☒ Groshong/Chest CVAD care per Salem Health CVAD Access Policy *(Lippincott)* for 2 weeks until healed, remove stay sutures, and no further dressings.

☒ 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.

☒ View Chest X-ray to verify catheter tip location PRN for: 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

☐ Other _____

_____ _____ _____

Provider Signature | Provider Printed Name | Date: