vitalcare of CROWN POINT

Pharmacy Name: Vital Care of Crown Point
Address: 1290 Arrowhead Court, Suite A
City/State/Zip: Crown Point, IN 46307

Phone: 219.295.4080
Fax: 219.600.1800

Patient Information

Patient Name | Parent/Guardian Name (if applicable) | ☐ All Insurance Info Attached

Address | City State Zip

Main Phone | Alternate Phone | Email

Date of Birth | Male | Female | Weight (required) kg lbs | Height (required) ft in

Allergies | Diabetic: No Yes

Medical Information

Primary Diagnosis | ICD-10 Code

Home Health Agency

Prescription and Orders

Medication	Dose	Frequency	Duration
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Pharmacy to dose based on current lab results? No Yes

1. IV Access:

_____ PICC Lines:
Weekly dressing changes unless integrity of dressing changes or becomes soiled. Securing device to be used unless line is sutured in. Flush with 10mL NS before and after each use and weekly when not in use. If administering TPN or drawing labs flush with 20mL NS after use. May use 5mL Heplock flush 100 unit/mL for sluggish line. Use only 10mL syringe or larger.

_____ Midline Catheter:
Weekly dressing changes unless integrity of dressing changes or becomes soiled. Securing device to be used unless line is sutured in. Flush with 10mL NS before and after each use
and weekly when not in use. If administering TPN or drawing labs flush with 20mL NS after use. May use 5mL Heplock flush 100 unit/mL for sluggish line. Use only 10mL syringe or larger.

_____ Peripheral IV:
Dressing change at site rotation every 72-96 hours or when clinically indicated. Flush with 5-10mL NS before and after each use. May use 3mL Heplock flush 10 unit/mL.

Other:

2. Anaphylaxis Protocol:
Epinephrine 0.3mg IM / Diphenhydramine 25-50mg by mouth PRN.

3. Labs Needed: _____

Frequency of Labs: _____ or ☐ Labs Per Pharmacy Protocol

4. Pull IV access when therapy is complete.

5. May discharge patient when therapy is complete.

Physician Information

Physician Name | DEA # | NPI # | License #

Address | City State Zip

Phone | Fax | Office Contact

I authorize Vital Care Infusion Services LLC and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Vital Care.

Physician Signature: _____

Date: _____

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

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