Maxor® SPECIALTY PHARMACY

Infusion Physician Order Form

PATIENT INFORMATION

PATIENT NAME: _____ DATE OF BIRTH _____

ORDERS

DX:

MEDICATIONS:

_____

_____

_____

_____

_____

_____

_____

_____

STOP DATE: _____

LAB ORDERS:

- ○ CBC
- ○ ESR/CRP
- ○ VANCOMYCIN THROUGH – TO BE DRAWN IMMEDIATELY PRIOR TO VANC
- ○ CMP
- ○ CK
- ○ OTHER: _____

LAB FREQUENCY:

- ○ WEEKLY
- ○ OTHER: _____

LINE TYPE:

TYPE: _____ #LUMENS: _____

☐ CVC DRESSING CHANGE WEEKLY OR: _____

FLUSHING INSTRUCTIONS:

- ○ SODIUM CHLORIDE 0.9%-10 ML; FLUSH IV CATHETER WITH 5 ML TO 10 ML AS DIRECTED
- ○ HEPARIN 100 ML/5ML – FLUSH IV CATHETER WITH 3 ML TO 5 ML AS DIRECTED
- ○ OTHER: _____

HOME HEALTHCARE AGENCY:	**PHONE:**
	FAX:

PRESCRIBER / DEA NUMBER / NPI:

PHYSICIAN SIGNATURE _____ DATE _____

PHARMACY INFORMATION

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