Infusion Services

A Department of Rutland Regional Medical Center

Prescription Order: Outpatient Infusion

Patient Name: _____

DOB: _____ Patient Phone _____

Allergies: _____

Instructions: please fill out this form completely. Fax to **802-772-2545** *(DI nursing)* *PLEASE SEND OV NOTES AND MEDICAL BENEFIT PA*

Order Sentence:

Give _____
Medication name and dose

Every _____ for _____
Frequency # of doses/time period

Diagnosis for infusion: _____

Special instructions/additional orders/comments:

Type of access/route:

☐Subcutaneous ☐Intramuscular ☐Peripheral IV ☐ Peripheral IV with ultrasound guidance

☐ Access/maintain PICC per protocol ☐ Access/maintain port-a-Cath per protocol ☐Other: _____

Is prior authorization required? ☐ Yes ☐ No (if "yes" please obtain authorization and attach documentation)

Provider Information:

Office Phone: _____ Fax: _____

Provider NPI: _____

Ordering Provider: _____ _____ Date: _____ Time: _____
Print name Signature

Patient Label