

Ambulatory Infusion Center Order

Enid Call: 580-977-1954 Fax: 580-548-1764	Canadian Valley Call: 405-717-6944 Fax: 405-553-5635	Grove Call: 918-787-3453 Fax: 918-787-3877	Miami Call: 918-540-7216 Fax: 918-540-7266	Portland Avenue Call: 405-949-3344 Fax: 405-604-4114 aic@integrishealth.org	Woodward Call: 580-254-8657 Fax: 580-254-8605	Ponca City Call: 580-765-2714 Fax: 580-763-0892
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Patient Name:	Address:	
DOB:	Phone:	
Diagnosis / Symptoms (ICD Code):		
Allergies:	Height (cm):	Weight (kg):

Insert IV? Y N Access Existing IV? Y N Port PICC Midline Hickman Power Line

IV THERAPY – HYDRATION – INJECTION – PORT FLUSH

Medication / IV Fluids	Route	DOSE*	RATE*	Frequency	Begin Date	End Date

INTEGRIS Health preferred, or payor approved formulary or biosimilar medication will be administered unless DAW indicated. DAW

Pharmacist to determine: Initial Dose Ongoing Dose Adjustment Rate

BLOOD TRANSFUSION

**** SPECIAL CONSENT for blood transfusion required (include with orders)****

Type & Cross: Y N Give: _____ units Packed Red Blood Cells Administer over _____ hours
Other: _____

Hgb _____ IV furosemide _____ mg between units

Lab: _____

PRN for Reaction/Anaphylaxis (ped max at adult dose if not otherwise specified):

<input checked="" type="checkbox"/> diphenhydramine 50 mg PO/IV x 1 <i>(*exclude for iron reactions)</i>	<input checked="" type="checkbox"/> methylprednisolone 125 mg IV x 1	<input checked="" type="checkbox"/> EPINEPHrine 0.3 mg IV every 5-15 min up to 0.5 mg x 3
Ped: diphenhydramine 1 mg/kg PO x 1 IV if already placed or PO unavailable	Ped: methylprednisolone 1 mg/kg IV x 1	Ped: EPINEPHrine 0.01 mg/kg IM Max 0.3 mg/dose (0.5 mg/dose adol)

OTHER SERVICES (specify below)

Provider signature
Provider Contact #:
Provider email:
Provider NPI:

Date/Time

Patient Label

