

Infusion Center

Physician Orders

Patient Name _____

Address _____

City _____ Zip _____ Phone _____

Allergies _____

Diagnosis _____

Medication
Orders: _____

IV Line Type: Peripheral _____ PICC Line _____ Midline _____

Lab Orders _____

(Routine Labs on Vancomycin or any Aminoglycosides are as follows:

Mondays, CBC, CMP, Trough Wednesday, BUN Creat.

If you have preferences, please indicate. All lab results will be faxed to your office routinely.

Physician Signature _____ Date _____

Nurse Receiving Order _____ Date _____

Office Number _____ Fax Number _____

*****Note: Please call to confirm order was receive via fax. Thank YOU!***