Wellscript
An Owens Company

CHICO
Phone: (530) 225-8898 | Fax: (530) 246-7366
REDDING
Phone: (530) 225-8898 | Fax: (530) 246-7366

WELLSCRIPT INFUSION PRESCRIBER FORM

Fax completed form, insurance information, and clinical documentation to Wellscript Infusion Pharmacy (530) 246-7366.

Patient Name:	Date of Birth:
Address:	
Phone:	Height: ☐ in ☐ cm
	Weight: ☐ lb ☐ kg

CLINICAL INFORMATION

ICD-10 Code/Diagnosis:

Allergies:

PRESCRIPTION

Please indicate medication, dose, frequency, route, and length of therapy:

ANCILLARY ORDERS

IV Flush Orders

☐ Peripheral:	NS 2 to 3 mL pre-/post-use. Heparin (10 unit/mL) 1 to 3 mL post-use. For maintenance, ☐ NS 2 to 3 mL every 12 hr *or* ☐ heparin (10 unit/mL) 1 to 3 mL every 24 hr.
☐ Peripheral-Midline:	NS 3 to 5 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw. Heparin (10 unit/mL) 3mL post-use. For maintenance, heparin ☐ (10 unit/mL) 3 mL every 12 hr *or* ☐ (100 unit/mL) 3mL every 24 hr.
☐ PICC and Central Tunneled/Non-Tunneled:	NS 5 mL pre-/post-use, 5 mL pre-lab draw, and 10 mL post-lab draw. Heparin ☐ (10 unit/mL) 5 mL ***or*** ☐ (100 unit/mL) post-use. For maintenance, heparin (10 unit/mL 5 mL *or* (100 unit/mL) 3mL every 24 hr.
☐ Implanted Port:	NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.
☐ Valved Catheters:	NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. For maintenance, NS 5 to 10 mL at least weekly.

* Nurse to perform central line dressing changes weekly and prn.

Lab Orders

☐ BMP ☐ CRP ☐ ESR ☐ No labs ordered at this time.

☐ CMP ☐ CBC ☐ Other: _____

Skilled nurse to assess and administer and/or teach self-administration where appropriate via access device as indicated above. Nurse will proved ongoing support as needed. Refill above ancillary orders as directed x1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

PRESCRIBER INFORMATION

Prescriber Name:	Phone:	Fax:
Address:	NPI:	
City, State:	Zip:	Office Contact: