Infusion/Specialty Pharmacy Home Services Order Form

Intermountain Health

IV: **385-887-7353** ENTERAL: **385-887-6333**

ROUTING	☐ IV ☐ ENTERAL
PATIENT NAME:	DOB:
Physician Following care after D/C:	PRIMARY CARE MD:
SERVICE ADDRESS:	PRIMARY CONTACT #:
	SECONDARY CONTACT #
PRIMARY INSURANCE CARRIER	GROUP/ID #
SECONDARY INSURANCE CARRIER	GROUP/ID #

HEIGHT:_____ CM WEIGHT:_____ KG

ALLERGIES:

INFUSION/SPECIALTY PHARMACY SERVICES ORDERED

IV

LINE TYPE: ☐ PICC ☐ TUNNELLED ☐ PERIPHERAL ☐ Port ☐ Accessed ☐ Deaccessed ☐ Midline ☐ Broviac

INSERTION DATE: _____ DRESSING CHANGE DUE: _____

OF LUMENS: ☐ 1 ☐ 2 ☐ 3 ☐ TPN ☐ LINE CARE ONLY

MEDICATION 1

DIAGNOSIS: _____

DOSE/FREQUENCY/ROUTE: _____ DURATION: _____

NEXT DOSE DUE: _____ REFILLS: _____ QTY: _____

HOOK UP AT ☐ HOME ☐ HOSPITAL ☐ MED SUPPLIES ONLY

TEACH AT ☐ HOME ☐ HOSPITAL ☐ NO TEACH NEEDED

MEDICATION 2

DIAGNOSIS: _____

DOSE/FREQUENCY/ROUTE: DURATION:

NEXT DOSE DUE: _____ REFILLS: _____ QTY: _____

HOOK UP AT ☐ HOME ☐ HOSPITAL ☐ MED SUPPLIES ONLY

TEACH AT ☐ HOME ☐ HOSPITAL ☐ NO TEACH NEEDED

ENTERAL

FORMULA: _____ DURATION:

DIAGNOSIS: _____ ☐ DISPENSE 30 DAYS

FORMULA VOLUME (mL/day): FORMULA CONCENTRATION (if applicable) kcal/oz:

TUBE TYPE: ☐ NG ☐ NJ ☐ JTUBE ☐ GJTUBE ☐ G-TUBE ☐ ORAL ☐ OTHER:

DELIVERY METHOD: ☐ PUMP ☐ SYRINGE/GAVAGE ☐ GRAVITY BAG

AMINISTRATION INSTRUCTIONS:

FEED RATE: _____ FEED SCHEDULE: _____

BOLUS VOLUME: _____ BOLUS FREQUENCY: _____

ADDITIONAL HYDRATION INSTRUCTIONS: _____

☐ SUPPLIES ONLY

☐ **NUTRITION ASSESSMENT AND ENTERAL/PARENTERAL NUTRITION FEEDING PLAN FROM INTERMOUNTAIN HEALTH RD.***

***Note:** the provider must sign the RD's proposed enteral/parenteral nutrition therapy order before it can be dispensed.*

PHYSICIAN SIGNATURE: _____ DATE _____

PHYSICIAN NAME (PRINT)

SUBMIT

Revised 11-26-2025