Intermountain Health

Home Services Pharmacy
11520 Redwood Rd, So Jordan, UT 84095
Phone: 385-887-6000 | Fax: 801-442-0709

INFUSION/SPECIALTY and ENTERAL PHARMACY HOME SERVICES ORDER FORM

PATIENT INFO	
PATIENT NAME:	**DOB:**
SERVICE ADDRESS:	**PATIENT PHONE:**
HEIGHT:	**WEIGHT:**
ALLERGIES:	

PROVIDER INFO	
ORDERING PROVIDER NAME:	**PRIMARY CARE PROVIDER:**
PROVIDER PHONE:	**PROVIDER PHONE:**
Does ordering provider have access to Epic Electronic Medical Record software? ☐ Yes ☐ No	

INSURANCE INFO (or submit a copy of patient demographic face sheet with this order)	
PRIMARY INSURANCE CARRIER	**GROUP/ID#**
SECONDARY INSURANCE CARRIER	**GROUP/ID#**

INFUSION/SPECIALTY PHARMACY ORDER

IV LINE TYPE: ☐ Peripheral ☐ PICC ☐ Tunneled ☐ Port ☐ Midline ☐ Broviac ☐ Other: _____
 # OF LUMENS: ☐ 1 ☐ 2 ☐ 3 ☐ LINE CARE ONLY
INSERTION DATE: _____ **NEXT DRESSING CHANGE DUE:** _____
IV LINE: ☐ Accessed ☐ De-accessed

☐ **For PARENTERAL Nutrition:** Check this box and/or call 385-887-6333 if the ordering provider would like **an Intermountain Health Home Services RD to perform a nutrition assessment and provide order recommendations**. If this box is checked, no need to fill out the remainder of this form, please submit as is.
****NOTE:** Provider will need to sign the proposed order BEFORE Parenteral Nutrition Therapy can be dispensed.**

MEDICATION 1 NAME:		
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 NAME:		
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 PHARMACY ORDER

☐ **For ENTERAL Nutrition:** Check this box and/or call 385-887-6333 if the ordering provider would like **an Intermountain Health Home Services RD to perform a nutrition assessment and provide order recommendations**. If this box is checked, no need to fill out the remainder of this form, please submit as is.
****NOTE:** Provider will need to sign the proposed order BEFORE Enteral Therapy can be dispensed.**

DIAGNOSIS:

FORMULA NAME(s): **EQUIVALENT ACCEPTABLE?:** ☐ Yes ☐ No

FORMULA VOLUME: _____mL/day | **FORMULA CONCENTRATION** (if applicable):_____calories/oz

☐ **Enteral Supply Only** (No formula)

TUBE TYPE: ☐ Naso-Gastric ☐ Naso-Jejunal ☐ G-Tube/PEG ☐ J-Tube ☐ GJ-Tube ☐ Oral ☐ Other: _____

Is the feeding tube a Button/Low-Profile?: ☐ No ☐ Yes, please specify French size _____ **and** cm length _____

DELIVERY METHOD:

☐ PUMP
Rate _____ mL/hr, for _____ hrs/day
Additional info:_____
☐ Pump Bag, 30/month (B4035/S9342)
☐ IV Pole (E0776) ☐ Pump (B9002)

☐ GRAVITY-DRIP BAG
Volume _____ mL/feeding, _____ times/day
OR _____ cartons/feeding, _____ time/day
☐ Gravity Bag, 30/month (B4036/S9341)
☐ IV Pole (E0776)

☐ SYRINGE BOLUS
Volume _____ mL/feeding, _____ times/day
OR _____ cartons/feeding, _____ times/day
☐ Syringe, 30/month (B4034/S9343)

ADDITIONAL HYDRATION: Volume _____mL/day, in addition to formula at goal

Daily Schedule: Volume _____mL water flush with syringe before and after feedings **-AND/OR-**
Volume _____mL water, _____ times/day by syringe **OR** every _____hours by syringe **-AND/OR-**
Flush Rate of _____ml/hr water every _____hours(s) by pump when running

MODULAR NAME(s): | **MODULAR DOSE/ADMINSTRATION INFO:**

PO INTAKE ALLOWED? ☐Yes ☐ No

SPECIAL INSTRUCTIONS:

Is Home Health Nursing needed?: ☐ Yes ☐ No

DISPENSE 30 DAYS

Length of Need: ☐ _____month(s) ☐ Lifetime ☐ Of long and indefinite duration

Refills:

PHYSICIAN/PROVIDER SIGNATURE: DATE:

PHYSICIAN/PROVIDER NAME (PRINT):

Send completed form to either Homecare@imail.org or fax 801-442-0709