STAT ☐

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Community HOSPITAL

Status:

DOB: Age:

Name:
Ref Phys:
Att Phys:
Prim Care Phys:

PROCEDURE CENTER

OUTPATIENT VASCULAR ACCESS ORDER FORM

Revised 2/6/2020

PATIENT NAME:	OFFICE PHONE #:
PATIENT PHONE #:	OFFICE FAX #:
ORDERING PROVIDER:	PATIENT DOB:
NURSE/MA:	PRIOR AUTH OBTAINED: ☐Yes ☐No
PATIENT ALLERGIES:	PRIOR AUTH #: (*required*)
LABS TO BE DRAWN:	PRIORITY: ☐ Routine ☐ STAT *(STAT not available for PICCs)*

DEVICE TYPE REQUESTED: ☐ PICC ☐ Midline ☐ US Guided Peripheral IV (USG PIV) ☐ Weekly dressing changes	DIAGNOSIS/ICD-10 CODE: *(required)* Z45.2: Encounter for adjustment & management of vascular access device ☐ _____

REASON FOR VASCULAR ACCESS DEVICE:

☐ Long-term antibiotic therapy: >4 weeks= PICC	☐ PPN: >4 weeks= PICC, <4 weeks= midline
☐ Short-term antibiotic therapy: (1-4 weeks)= midline	☐ TPN: PICC
☐ Poor peripheral venous access: midline or USG PIV	☐ Chemotherapy
☐ Vesicant therapy: PICC	

☐ For loss of line patency, I authorize use of the Community Hospital Thrombolytic Protocol.

☐ Discussion of Procedure:

I, as the ordering provider, have discussed placement of the ordered venous access device with the patient/family; including its risks, benefits, and alternatives; I have answered their questions to the best of my ability.

Provider's Signature: _____ Date: _____

Order expires one year from written date.

NAME: **DOB:**