MIC METRO INFUSION CENTER

Central Venous Care and Maintenance

Name: _____
DOB:_____

Any allergies to chlorhexidine/tape/heparin:
☐Yes ☐No

Dose calculation:
N/A

Dosing Guidelines/Parameters: ***Provider must select hold parameters that will trigger a call from the Infusion Staff***
N/A

Hydration Orders:
N/A

Premedication and Antiemetic Orders:
N/A

Metro Infusion Center Care and Maintenance:

Choose type of CVC patient has:

☐ **Implanted Port** access is sterile and a sterile dressing will be applied. We will flush with each infusion. If needed between infusion visits, port flushes will be maintained by the referring office.

☐**PICC line** dressings will be changed on day of infusion at MIDC/MIC. Dressings needed on weeks when the patient is not getting infusions will be maintained by referring office.

Flushing protocol (choose one protocol):

☐ Flush CVC as per MIDC/MIC standard policy. 10ml NS followed by 3-5ml 100unit/ml Heparin (Ports 5ml; PICC based on internal diameter of line)

☐ Flush CVC with saline (10ml of NS; no heparin)

Alteplase

☐ MIC staff can use alteplace PRN (cath flow activase) to re establish blood return from CVC if no blood return noted

This order is good for 1 year from the date ordered

Other:

Call referring provider for:

Date:

Referring Provider:_____ _____ Phone# _____
SIGNATURE REQUIRED PRINTED NAME REQUIRED

Office Contact name/number:

All information in this order is strictly confidential and will become part of the patient's medical record. Contact us with questions at (877)448-3627. Send completed form and all documentation to confidential email: MICreferral@metroinfusioncenter.com or fax to (866)507-1164

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