Out-Patient PICC Order
Please fax order to 580-585-5472

PATIENT DEMOGRAPHICS:

PATIENT NAME: _____ **PATIENT'S CONTACT #:** _____
DATE OF REFERRAL: _____ **ADDRESS:**_____
DATE OF BIRTH:_____ **CITY, STATE, ZIP:** _____
INSURANCE: _____
HEIGHT: _____ **INCHES** **WEIGHT:** _____ **KG** **GENDER: FEMALE** ☐ **MALE** ☐
ALLERGIES: ☐ **NKDA**

PRIMARY DIAGNOSIS:

☐ _____

INDICATION FOR THERAPY:

☐ **ANTIBIOTICS > 5-7 DAYS** ☐ **NO PERIPHERAL ACCESS** ☐ **TPN** ☐ **OTHER**_____

MEDICAL HX:

☐ **ESRD**
☐ **ESRD ON DIALYSIS**
☐ **PACEMAKER** ☐ **LEFT** ☐ **RIGHT**
☐ **MEDIPORT**
☐ **MASTECTOMY** ☐ **LEFT** ☐ **RIGHT**
☐ **CRUTCHES**
☐ **HX OF DRUG ABUSE**
☐ **BLOOD THINNERS** _____
☐ **PREVIOUS STROKE** ☐ **LEFT** ☐ **RIGHT**
☐ **PREVIOUS SHOULDER SURGERY** ☐ **LEFT** ☐ **RIGHT**
☐ **PREVIOUS CENTRAL LINE**
☐ **CREATININE** _____ date drawn (if creatinine > 2.0 approval from patient's primary care physician or nephrologist required, if patient is on dialysis approval from nephrologist required)
☐ **PLATELETS** _____ date drawn (if platelet level is <50 approval from patient's primary care physician required)
☐ **OTHER RELEVANT CLINICAL INFORMATION**
_____

ORDERS:

☐ **Single lumen PICC Insertion ** INCLUDE CONSENT FORM SIGNED BY ORDERING PHYSICIAN****
☐ **Midline (IV therapy for 4 weeks or less)**
☐ **Accucath**
☐ **Chest x-ray post catheter insertion to confirm placement**
☐ **Apply transparent dressing and change per CCMH policy or when visibly soiled**

Prescriber Information:

Physician Name: _____ **Contact #:** _____
Fax Number: _____ Address: _____
NPI #: _____**DEA #:** _____ **State License #:** _____

_____ _____
Physician **Date** **Time**