PURE
INFUSION SUITES

PORT FLUSH ORDERS

UTAH PROVIDERS Fax form to:
1-801-991-6924

ALL OTHER PROVIDERS Fax form to:
1-801-931-2631

you must enter a 1 before the fax number

Patient's Information

Date of Referral

First Name | Last Name | M.I.

Date of Birth

Address

City | State | ZIP Code

Phone

WT (kg) | HT (in)

Diagnosis

Allergies

*ICD 10 CODE

***Please include supporting clinical documentation for the specified ICD 10 Code as well as demographic and insurance information. This is necessary to ensure payment by the insurance carrier. Please fax with this order form. Initial appointment date and time will be verified after insurance approval.**

IV Port Flush

☐ Access and De-access implanted port for medication administration, lab draw, and port flush. Flush port with 10ml normal saline after each use and every 3 months when not in use.

In addition to normal saline:

☐ Flush port with heparinized saline solution:

Dose: ☐ 10unit/ml ☐ 100unit/ml ☐ Other

Amount: ☐ 3ml ☐ 5ml ☐ Other

☐ Do not flush with heparinized solution

Catheter Occlusion:

☐ Use Cathflo Activase for catheter occlusion:

- ☐ Instill 2mg/2ml in occluded catheter, repeat x1 if no blood return after 120 minutes
- ☐ Other:

☐ Do not use Cathflow Activase for catheter occlusion, notify provider for occlusion.

Prescribing Provider

Address

City | State | ZIP Code

Provider Signature

Date / Time

Provider Phone | Provider Fax