Lewis County Health System

7785 North State Street
Lowville, New York 13367
Phone 315-376-5200
Fax 315-376-0130
www.lcgh.net

CONFIDENTIAL

DATE: _____

PLEASE DELIVER TO: Lewis County Health System – ASU Department

FAX #: 315-376-0130

COMPANY: _____

FROM: _____

NUMBER OF PAGES (INCLUDING COVER SHEET): 3

SUBJECT: **INFUSION REQUEST**

NOTES: _____

_____

_____

_____

Lewis County Health System
Your Health Partner

OUTPATIENT SERVICES REQUEST CHECKLIST

What is needed to schedule your patient for treatment at Lewis County General Hospital

Patient Name _____ **DOB** _____ **Patient Phone #** _____

Height _____ **Weight** _____ **Gender** _____ **Allergies** _____

Please attach separate order form for Infusion or procedure (i.e., wound care)

_____

Diagnosis/Indications for treatment:

_____

Please ensure the following are attached:

☐ **Authorization / Insurance approval completed**

Reference # _____ Date _____

Authorization # _____ Date _____

☐ **Patient Demographic Cover Sheet**

☐ **LCGH specific Order Sheet completed in full?**

- ☐ Patient's name
- ☐ Patient's DOB
- ☐ Diagnosis
- ☐ Patient's current height and weight
- ☐ Allergies
- ☐ Signed, dated, and timed by ordering physician

☐ **Consent completed** (for blood products including IVIG)

☐ **H&P written within 30 days** (which includes purpose for drug)

☐ **Print and fax to LCGH Ambulatory Outpatient Department**

Please make sure **ALL boxes are checked prior to faxing to LCGH ASU
Upon completion, scheduling will be done by LCGH

Provider (or designee) Print Name _____ **Phone #** _____ **Fax #** _____

Provider (or designee's) Signature _____ **Date** _____

Fax completed form to: 315-376-0130 / Contact us directly at: 315-376-5233 / Visit us online at: lcgh.net

Lewis County Health System

DOCTOR'S ORDER SHEET - PHARMACY

Place **patient identification sticker** and/or **two patient identifiers.**

PICC LINE INSERTION, DRESSING, CHANGE, BLOOD DRAW FROM PICC LINE, AND DISCONTINUATION / REMOVAL OF PICC LINE

ORDERS GOOD FOR THE YEAR OF 20_____

☐ **Admit to ASU Outpatient**

Diagnosis:

Allergies:

Vital Signs: _____

Code Status: _____

☐ **Insert PICC Line**

☐ **PICC Line Dressing Change - Weekly**

☐ **Draw for Labs?** ☐ Yes ☐ No

Lab Draws:

☐ CBC ☐ CMP ☐ Hgb & Hct ☐ Other (Please specify) _____

PICC Line is ☐ **Single Lumen** ☐ **Double Lumen**

☐ **Flush each lumen with 20 mL of 0.9% Normal Saline after blood draw complete**

☐ **Remove PICC line per policy**

☐ **Discharge when criteria met.**

Qualified Medical Provider Name (Print) : _____

Signature: _____ **Phone Number:** _____

NPI#: _____ **Date:** _____ **Time:** _____

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