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: ______________________

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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.**

PORT FLUSH

ORDERS GOOD FOR THE YEAR OF 20______

☐ **Admit to ASU Outpatient**

Diagnosis:

Allergies:

Vital Signs: ________________________________

☐ **Access port per LCHS Policy / Protocol**

Frequency:
- ☐ One-time Order
- ☐ Bi-Weekly Order
- ☐ Monthly Order
- ☐ Other (Please specify) ________________

☐ **Flush Port With: 0.9% Normal Saline 10 mls followed by Heparin 500 units**

☐ **Special Flush Instructions (Please Specify)** ________________________________

Lab Draws:

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

☐ **Discharge when criteria met.**

Qualified Medical Provider Name (Print) : ________________________

Signature: ________________________ **Phone Number:** ________________

NPI#: ________________ **Date:** ____________ **Time:** ____________

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