



General

Patient Name _____ DOB _____

Guidelines for Ordering:

1. Please provide Port Information:

Port Placement Date: _____

Type of Port (ex. PowerPort, Port-a-Cath): _____

Port Access

Access implanted port with a ____ gauge ____ inch port access kit per KVH Lippincott procedure "Implanted Port Accessing".

Labs (*please specify date(s) and labs to be drawn*)

May obtain labs from port prior to infusion(s):

Port Deaccess

Flush port with 20mL sodium chloride 0.9%, then Heparin lock with 500unit/5mL heparin flush, Deaccess port, and apply sterile gauze dressing to site.

Ordering Facility/Provider Information

By signing below, I affirm the following:

I am responsible for the care of the patient identified on this form.

I hold an active, unrestricted license to practice medicine in _____ (specify state)

My physician license number is # _____ and I am acting within my scope of practice and authorized by law to order infusion of the medication described above for the patient identified on this form.

Provider Signature: _____ Date _____
Printed name: _____ Phone: _____ Fax: _____

KVH Provider Co-signature: <i>*Required for all external orders</i>	
Provider Signature: _____ Date _____	
Printed name: _____	

<i>Patient Name:</i> <i>DOB:</i>
