St. Anthony
Summit Medical Center
Centura Health.
Here, we treat you as a person first.

Ambulatory Care Order Form

 4/2016

For Referring Office to Complete – ALL FIELDS REQUIRED
Referring Physician:
Date/Time of Issue:
Patient Name:
DOB:
Home: Cell:
Requested Start Date:
Duration of Treatment:
End Date of Orders:
CPT & ICD10 Codes: _____________ / _______________
Insurance:____
SASMC Tax ID: 840405257 NPI: 1720096092
☐ **No Pre-authorization needed**
Reference Number:_____________________________
☐ **Pre-Authorization Number#________________________**
Start Date_______________ End Date_______________
Physician Office Contact:
Phone #:
Fax #:
FAX Completed Orders to 970-668-6331
Ambulatory Care and Infusion Services are Available Monday-Thursday 0830-1730, except holidays.
Infusion Center Main Phone #: 970-668-6710
*Include current H&P, Demographics, Face sheet, Insurance Card
*For Blood, a signed Summit Medical Center Consent must accompany this order form. Valid for 1 year.
Infusion Center Use: Date and Initial
Reviewed by RN: ☐ Verified with Pharmacy: ☐
Dora Verified: ☐
Therapy Plan Entered by RN ☐
Referral Verified/Entered ☐
Scanned to MR ☐
Notified Candace ☐ Approved:
Pharm Notified: ☐ Drug Available____________
E-mailed to Pharmacy ☐
Scheduled for:______________________

Referring Physician To Complete

Pt Allergies: ________________________________

Diagnosis:________________________________

☒ Admit: Ambulatory Care ☐ Recurring Patient
☒ Vital Signs per Routine ☒ Regular Diet

☐ Establish IV Access
☐ PICC Care Per Centura Policy. NS Lock solution
* NS Flush 10ml Before & after each medication
* DSG change Q week. Pulsatile flushing clamp at end of flush.
☐ Port Care Per Policy- Heparin 100units/ml 5ml IVP prior to de-access. Refer to IV Central Line (Centura)

Labs to be drawn:

☐ CBC with Differential ☐ Basic Metabolic Panel
☐ Hematocrit/Hemoglobin ☐ C-reactive protein
☐ Type and Cross
☐ ____

Fax Results to____________________________________

Medications to be given:
(Include: **Dose, Frequency, Route**)
☐ ____
☐ ____

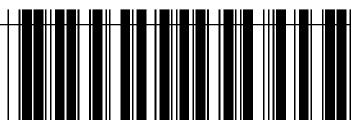
****Height and Weight must be entered for med to release.**

Blood Transfusion
****CONSENT Filled Out/Attached:** ☐
Post Transfusion Education Attached: ☐
Transfuse ________ Unit/s
☐ Packed Red Blood Cells
☐ Platelets ☐ Irradiated/Leukoreduced

Other (pre-medications, wound care orders, treatment parameters)
☐ ____
____
____
____

☒ Discharge patient when stable and if no adverse reactions

______________________ ______________
Referring Physician Signature **Date/Time**


PHYORD

PATIENT BARCODE LABEL MUST BE PLACED IN THIS SPACE

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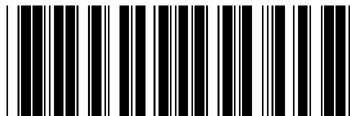

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IN THIS SPACE