Goshen Hospital

Infusion Center Phone: 574-364-2963
Email order to Infusion Center: infusioncenter@goshenhealth.com

Infusion Center Order Set

DEMOGRAPHICS

Name: ____Birthdate:___________ M____F______

Address:________________________________City:______________________State:____Zip:_________

Preferred patient phone #:_________________________Social Security#___________________________

Contact person if not patient: _______________________Relationship:__________Phone #:_____________

Language preferred:_________________Interpreter Services Needed: Y_____N_____

INSURANCE

Insurance Co.________________________Policy#_____________________ Group #________________
Authorization # _____________________ Date Span:__________________ Contact_________________

ORDERING PROVIDER

Ordering Provider:______________________________________Specialty__________________________

ORDERS

Diagnosis/ICD-10 Code(s): ____
Allergies: ❑ NKA ❑ List: ____________________________ ❑ Dressing changes per protocol

IV Access: ❑ Implanted port ❑ PICC line ❑ Midline ❑ Med Lock ❑ Remove IV access date:

Labs: ❑ CBC ❑ BMP ❑ CMP ❑ ESR Frequency ______________________________
❑ Other: ____________________________________Frequency:______________________________
Send results to:_______________________________ Fax number:______________________________

Transfuse: ❑ Packed cells _____ units ❑ Fresh Frozen Plasma _____ units ❑ Platelets _____ units

MEDICATION	DOSE	UNIT Please circle	ROUTE Please circle	FREQUENCY OR INSTRUCTIONS Indicate if PRN
		mg mcg Gram ml units	PO IM Neb IV SQ	
		mg mcg Gram ml units	PO IM Neb IV SQ	

Nurse Signature:	Date:	Time:	❑ T.O. ❑ V.O. ❑ R& V
Provider Signature:	Date:	Time:	

Revised 9-13-18