Goshen Hospital

Infusion Center Phone: 574-364-2400, option #2
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