Outpatient Central Line/Port Care Referral and Order Form

You may submit a face sheet from your organization in lieu of completing the Demographic and Financial Information below, provided all information requested is present. For questions please call (360) 346-2274

PATIENT DEMOGRAPHIC INFORMATION:

Name: _____ Date of Birth _____

Address: _____ City, State, Zip:_____

Phone Number: _____

FINANCIAL INFORMATION:

Insurance:_____ Subscriber:_____

Policy#_____ Group#_____ Effective Date:_____

Service Authorization (phone) _____ (fax)_____

<u>This Section for Internal use only:</u>

Prior Authorization Required: Yes ❑ No ❑ Prior Authorization #:_____

Authorization Approval Date: ____/____/____ thru ____/ ____/ ____ J Code:_____

Applicable CPT Codes: _____ _____ _____

Additional Comments: _____

_____

_____

SUMMIT PACIFIC
• MEDICAL CENTER •
600 E Main
Elma, WA 98541

PATIENT LABEL (for internal use only)

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PATIENT CLINICAL INFORMATION:

Height: _____ Weight: _____ Kg or lbs (circle one)

Allergies: _____

Diagnosis/ICD10 Code: _____(orders without diagnosis codes will not be accepted)

☐ Include most current clinic note or labs that indicate medical necessity for medication/order.

ORDER INFORMATION:

Order Date:_____ (Expires in 1 year OR ____/____/____) Line/Port Type: _____

Flush every _____ Dressing change required: Yes ❑ No ❑ Every: _____ days

5mL Heparin Lock (100units/mL): Yes ❑ No ❑

Alteplase 2mg IV PRN for occluded lumen ❑ Yes ❑ No

IV Access:

☐ Access central line/port per RN discretion and SPMC protocol.

VITALS:

☐ Per SPMC Protocols

☐ Other: _____

LABS:

☐ CBC

☐ CMP

☐ Other: _____

☐ Each port flush

☐ Every _____

Fax results to: _____

PROVIDER INFORMATION:

Signature: _____ Name (print): _____

Date: _____ NPI#_____ Phone Number: _____

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