Northwestern Medicine

Vascular Access Device Care/Maintenance

Order Processing: Fax Form: **CDH PTC: Fax (630) 933-2444** *Phone (630)933-6272* **Delnor OPIC: Fax (630)208-3467** *Phone (630)208-4446*		
Patient Name:	**DOB:**	**MRN** ***(if known)***
Height: cm	**Weight:** kg	
Allergies (list all with reactions):		

Diagnosis and Code REQUIRED for submitting form

Diagnosis:_____Code:_____

Please complete all applicable fields to avoid any delays in scheduling or phone calls for clarification.

P**atient has the following for venous access*: Circle if applicable* PORT PICC Peripheral Central Line**

Line Care and Maintenance

- ☐ Alteplase (ACTIVASE) injection 2 mg, intercatheter, ONCE PRN, for occluded device
- ☐ Heparin (porcine)(PF) injection 500 UNITS/5mL, PRN, Line Care Port Flush
- ☐ Sodium Chloride flush 0.9% syringe 10-20mL, intercatheter, PRN, Line Care, Port Flush.
- ☐ Other Order:_____

Lab	Frequency	Day of the week if indicated	OR Dose Number
CBC-Hemogram			
CBC-Diff			
CMP			
BMP			
Hepatic Function Panel			
Other:			
Other:			

Nursing Orders

- ☑ Infusion Nurse to assess the patient's vascular access and initiate orders for line care per department policies and procedures.

Provider Name: _____Signature:_____

Date: _____ Time: _____