



MATAGORDA REGIONAL
 MEDICAL CENTER
 MRMCM IV THERAPY SERVICES
 PHONE: 979-241-5966
 FAX: 979-241-5965

DOPAMINE ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI _____ DOB: _____
 HT: _____ WT: _____ Sex : () Male () Female SSN: _____ Home #: _____ Cell#: _____
 Street Address _____ City/State/Zip _____
 Allergies: _____

INSURANCE INFORMATION

Primary Insurance Name _____ Policy ID #: _____
 Secondary Insurance Name _____ Policy ID #: _____

PHYSICIAN / FACILITY INFORMATION

Physician Name _____ Contact Name _____ Contact Phone # _____
 Address: _____ City/State/Zip _____
 DEA#: _____ NPI #: _____ State Lic #: _____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD-10 Code plus Description) _____ Date of Diagnosis: _____

Does the patient have venous access? Yes No If Yes, what type? _____
 If No, does patient need venous access? Yes No If Yes, what type? PIV (HepLock) PIV (No HepLock – DC after each visit) PICC MediPort

PRESCRIPTION ORDERS

- a) ALL MEDIPOINTS / IV ACCESSES WILL BE FLUSHED WITH HEPARIN OR SALINE PER HOSPITAL PROTOCOL PRN
- b) ADMINISTER CATH-FLO 2MG, IVP IF PICC LINE BECOMES SLUGGISH OR OCCLUDED: MAY REPEAT AFTER 2HRS IF NEEDED X 1.
- c) HOSPITAL PHARMACY WILL FOLLOW AND ADJUST ALL DOSING FOR VANCOMYCIN, GENTAMYCIN, AND PATIENTS WITH RENAL INSUFFICIENCY PER HOSPITAL PROTOCOL

DO NOT ADMINISTER HEPARIN TO THIS PATIENT

DRUG 1	DOSE	ROUTE	FREQUENCY	DURATION
Dopamine	2mcg/kg	IV	6 hours	3 Days
DRUG 2	DOSE	ROUTE	FREQUENCY	DURATION
Lasix	40 mg	IV	BID	3 Days
DRUG 3	DOSE	ROUTE	FREQUENCY	DURATION
DRUG 4	DOSE	ROUTE	FREQUENCY	DURATION

LABS

NOTES/INSTRUCTIONS/OTHER

SELECT BELOW	LAB REQUESTED	FREQUENCY
<input type="checkbox"/>	CBC w/ Diff	
<input type="checkbox"/>	BMP	
<input type="checkbox"/>	CMP	
<input type="checkbox"/>	BUN/CREATININE	
<input type="checkbox"/>	ESR	
<input type="checkbox"/>	CRP	
<input type="checkbox"/>	CPK	
<input type="checkbox"/>	Other:	
<input type="checkbox"/>	Other:	

Daily Weights and I & O's

FLUSHES: 10 mL NS Flush Syringe PRN Heparin 500 units/5 mL Flush Syringe PRN NS 50 mL PRN

Physician's Signature _____ Time _____ Date _____

Fax completed form to the MRMCM Infusion Center at 979-241-5965.
 PLEASE include copies of: H+P, OFFICE NOTES, LABS, ACTIVE MEDICATION PROFILE, and CURRENT INSURANCE INFORMATION in order for your referral to be processed. Reviewed 04/2026