



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

**GENERAL IV 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 |
|--------|------|-------|-----------|----------|
|        |      |       |           |          |
| DRUG 2 | DOSE | ROUTE | FREQUENCY | DURATION |
|        |      |       |           |          |
| DRUG 3 | DOSE | ROUTE | FREQUENCY | DURATION |
|        |      |       |           |          |
| DRUG 4 | DOSE | ROUTE | FREQUENCY | DURATION |
|        |      |       |           |          |

**LABS**

**NOTES/INSTRUCTIONS/OTHER**

| SELECT BELOW | LAB REQUESTED  | FREQUENCY |  |
|--------------|----------------|-----------|--|
|              | CBC w/ Diff    |           |  |
|              | BMP            |           |  |
|              | CMP            |           |  |
|              | BUN/CREATININE |           |  |
|              | ESR            |           |  |
|              | CRP            |           |  |
|              | CPK            |           |  |
|              | Other:         |           |  |
|              | Other:         |           |  |

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 MRMCMC 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