HAI GLYCERIN PRESCRIPTION FORM

Fax to 877-734-5872 or attach to e-referral

Patient Detail

Name: Sex: ☐ M ☐ F DOB:

Parent or Legal Guardian, where applicable:

Address: City: State: Zip Code:

Phone: Email Address:

Allergies:

Prescriber Detail

Prescriber Name: NPI: License #:

Address:

Phone: Fax: Email:

Prescription Order

If pump contains heparinized saline or floxuridine, rinse pump with 30 mL of Glycerin

	Product	Directions
☐	Sterile Glycerin 50% v/v Solution	RN to instill 30mL into implanted Intera 3000 pump to maintain catheter patency
☐		

Refill as needed x 1 year to maintain catheter patency

Nursing Orders

Skilled nursing services as needed for pump refills and monitoring. Plan of treatment will be submitted after the initial nursing visit. I acknowledge that I will be periodically reviewing and signing the written Plan of Treatment in accordance with state regulation.

Prescriber signature

I certify that the use of the indicated treatment and services ordered above are medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: **Date:**