Atrium Health Wake Forest Baptist

Referral Status:	☐ New Start ☐ Order Change ☐ Renewal
Preferred Location:	☐ Atrium Health Wake Forest Baptist Infusion - Westchester **Fax 336-802-2389**

Port Flush Order (Revised 08.25.2026)

All orders with a √ will be placed.

Patient Demographics:		
Patient Name:		Date of Birth:
Address:		
City:	State:	Zip Code:
Allergies: (please list all allergies or attach list)		
☐ NKDA		
Diagnosis:		
☐ ICD-10:		

Required Documentation: (*required prior to scheduling*)	
Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy:
Copy of Insurance Card (front and back)	
Most Recent Labs (*must include labs pertinent to medication ordered*)	☐ No Washout Needed
Consult Note or last 2 Office Visits with referring provider or APP	If the patient is currently on the therapy, indicate date of last infusion: Next infusion due date:
Complete Medication List - Include all tried and failed meds	If this is an order change only, indicate if the current therapy should be administered until insurance approval is received for the new request.
Diagnostic Studies Pertinent to Medication Ordered	☐ Yes ☐ No

Nursing Communication:
☑ Access CVC.
☑ Obtained vital signs PRE- and POST- port flush PRN.
Infusion Therapy:
☑ Port Flush per Atrium Health Protocol Frequency: every _____ weeks
Hypersensitivity Protocol:
☑ Initiate Atrium Health Wake Forest Baptist approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity protocol can be found on the Atrium Health Wake Forest Baptist Infusion - Westchester website at www.wakehealth.edu/locations/clinics/i/infusion-

Prescriber Information:		
Provider Name:	Phone:	Fax:
Practice Name:	NPI:	
Address:	Office Contact:	
City, State, Zip:	Office Contact Phone Number:	
Physician Signature: (*Order expires 12 months from date of signature*) No Stamp Signatures Accepted		
Signature:	Date:	