Spectrum Health

Physician's Orders WOUND CARE - ADULT, OUTPATIENT, INFUSION CENTER

Patient Name
DOB
MRN
Physician
FIN

Defaults for orders not otherwise specified below:
- ☐ Interval: Once
- ☐ Interval: Every _____ day(s)

Duration:
- ☐ Until date: _____
- ☐ 1 year
- ☐ _____# of Treatments

Anticipated Infusion Date_____ ICD 10 Code with Description_____

Height_____(cm) Weight_____(kg) Allergies_____

Provider Specialty

☐ Allergy/Immunology	☐ Infectious Disease	☐ OB/GYN	☐ Rheumatology
☐ Cardiology	☐ Internal Med/Family Practice	☐ Other	☐ Surgery
☐ Gastroenterology	☐ Nephrology	☐ Otolaryngology	☐ Urology
☐ Genetics	☐ Neurology	☐ Pulmonary	☐ Wound Care

Site of Service

☐ SH Gerber	☐ SH Lemmen Holton (GR)	☐ SH Pennock	☐ SH United Memorial
☐ SH Helen DeVos (GR)	☐ SH Ludington	☐ SH Reed City	☐ SH Zeeland

Appointment Requests

☑ Infusion Appointment Request

Status: Future, Expected: S, Expires: S+365, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Wound Care appointment

Procedure

☑ **SIGN ORDER** for Prior Auth (**DO NOT RELEASE**) Therapy Plan Order

Other, Once, Starting S, For 1 Doses

This order must be selected and signed to generate and send a referral to the designated Therapy Plan Treatment Department.

Nursing Orders

☑ Wound Care

Anatomical Area:
- ☐ Coccyx
- ☐ Sacrum
- ☐ Foot
- ☐ Heel
- ☐ Leg
- ☐ Other: _____

Laterality:
- ☐ Left
- ☐ Right
- ☐ Posterior
- ☐ Other: _____

CONTINUED ON PAGE 2 ➔

NOTE: ***Epic Treatment/Therapy Plan Orders. To be scanned/attached to the appropriate Infusion Referral Order in Epic.***

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

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WOUND CARE - ADULT, OUTPATIENT, INFUSION CENTER *(CONTINUED)*

Patient Name

DOB

MRN

Physician

FIN

Cleansing:

- ☐ Soap & Water
- ☐ Warm Sterile 0.9% Normal Saline
- ☐ Wound Cleanser
- ☐ Peroxide Hydrogen 3%, 4 oz
- ☐ Other: _____

Peri-skin Wound Care: _____

Primary Wound Dressing: _____

Secondary Wound Dressing: _____

Dressing Change Type:

- ☐ Clean
- ☐ Sterile

Affixation: _____

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Telephone order/Verbal order documented and read-back completed. Practitioner's initials _____

NOTE: Unless Order is written DAW (dispense as written), medication may be supplied which is a generic equivalent by nonproprietary name.

TRANSCRIBED: TIME	DATE	VALIDATED: TIME	DATE	ORDERED: TIME	DATE	Pager #
	Sign		R.N. Sign		Physician Print	Physician

EPIC VERSION DATE: 04/01/19

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