



**Ambrosia Healthcare, Inc.**

### Prescriber Order for C-II Prescription

<b>Prescriber:</b>	<b>Prescriber Address:</b>	
<b>Credentials:</b>		
<b>Prescriber Phone #:</b>	<b>Prescriber DEA #:</b>	
<b>Prescriber Fax #:</b>	<b>Prescriber NPI #:</b>	
<b>Patient Name:</b>		<b>DOB:</b>
<b>Diagnosis/ ICD-9:</b>	<b>Allergies:</b>	

Please Review and make changes as necessary, sign, and fax back to (888)505-3006.

**Orders:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Heparin IV \_\_\_\_\_ units/ml flush post infusion and p.r.n.     1-3 ml     3-5 ml     5 ml

NS     D5W flush pre/post infusion and p.r.n.     1-3 ml     3-5 ml     5-10 ml

NS 5-20 ml VAD flush pre/post lab draw     Other Flush Orders: \_\_\_\_\_

Supplies/ Pump/ Pole as appropriate to administer ordered therapy \_\_\_\_\_

Pump Type: \_\_\_\_\_

Laboratory Orders: \_\_\_\_\_

Home Health Agency Name: \_\_\_\_\_

Home Health Agency Address: \_\_\_\_\_

Home Health Agency Telephone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

DEA #: \_\_\_\_\_ NPI #: \_\_\_\_\_ (If different from above information)

**Faxes received by AHL after 5p.m. will be handled the following business day. If immediate attention is required, please contact us by telephone**

Pharmacist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Patient/ Caregiver Signature: \_\_\_\_\_ Date/ Time: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_