BRONSON

Affix Patient Label

Patient Name: Date of Birth:

Order for Accessing Central Venous Catheter

Testing to be done at: ☐ BMH/BBC/BLH Fax to: (269) 341-6792 ☐ BSH Fax to: (269) 639-2829

Patient Name: _____ DOB: _____

Allergies/Reaction: _____ Diagnosis(es): _____

Reason for access: ☐ IV access needed for outpatient imaging ☐ Other: _____

Orders:

☐ Start Peripheral IV or Access Central Venous Catheter and Initiate Outpatient Flush Protocol

Physician/Provider Name *(print)*: _____

Physician/Provider Signature: _____ Date: _____ Time: _____