Provider Order Form

DESMOPRESSIN (DDAVP), IV

Uptiv Health

PATIENT

Full Name: _____ DOB: _____

Mobile Phone: _____ Weight: _____ ☐ lbs ☐ kg

Allergies: _____ ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

☐ Hereditary factor VIII deficiency: hemophilia A D66 ☐ Other: _____

☐ Von Willebrand's Disease D68.0 _____

PROVIDER

Provider Name: _____ Provider NPI: _____

Practice Name: _____ Referral Coordinator Name: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☐ Desmopressin (DDAVP), IV	☐ 0.3 mcg desmopressin acetate/kg body	☐ Once
		☐ _____
☐ Other: _____		

Refills ☐ Zero ☐ 12 months ☐ _____ Order valid for 1 year unless otherwise stated. _____

☒ Infused slowly over 15 to 30 minutes.

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

☐ CBC	☐ at each dose	☐ every _____
☐ CMP	☐ at each dose	☐ every _____
☐ CRP	☐ at each dose	☐ every _____
☐ Other _____	☐ at each dose	☐ every _____

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX

Provider Signature _____ Date _____