Department of Pathology and Laboratory Medicine
111 Colchester Ave., Burlington, Vermont 05401
Phone: 802-847-5121 or 800-991-2799

FAXED LABORATORY ORDER FORM
CVAD (CENTRAL VENOUS ACCESS DEVICE) Blood DRAWS

This form is to be used as follows:

1. For clinicians who wish to fax in a standing order to implement CVAD Care and Maintenance protocol*
2. By the laboratory for documenting a standing order to implement CVAD Care and Maintenance protocol*

If you are faxing in an order, please complete all the information, print legibly and provide an authorized signature* below.
Fax this form to us at 802-847-5905 as promptly as possible. Thank you

Laboratory Customer Service Use

Date Order Requested ____/____/____ Time _____

Who called? _____ Location_____

Patient Full Name_____ Date of Birth_____/_____/_____

FAHC MRN# _____

Clinician Office Use

Please review an excerpt from the policy "CENTRAL VENOUS ACCESS DEVICES (CVAD) Care and Maintenance"

Excerpt from the policy: All venous access devices must be flushed with at least 10ml of 0.9% sodium Chloride before and after accessing, and all non- valved devices require flushing with Heparin or Saline to maintain patency of the line. The physician's order for drawing blood samples includes the appropriate care and maintenance of line before and after accessing the device, including flushing of the line per protocol. If it cannot be determined if the venous access device is valved, care and maintenance of the line includes Heparin or Saline flush post procedure to assure patency. An order to implement this protocol will be obtained from the authorized clinician who ordered the blood testing.

NOTE: The entire policy is available for review at http://www.fletcherallen.org/upload/photos/6404CVAD_policy-final__2_.pdf

□ I agree to the care and maintenance of the Central Venous Access Device as described above.
(This order will remain in effect for a period of 1 year from the date signed.)

□ I wish to Decline the use of University of Vermont Medical Center's Central Venous Access Device Care and Maintenance Protocol.
Declining authorization for use of the CVAD protocol will necessitate the use of a venipuncture.

➔ **Authorized* Signature**: _____

Print Name: _____

***The following clinicians can provide an authorized signature (MD, DO, NP, PA, CNM, and CSW).**

Date_____ Time _____