

**FLETCHER ALLEN HEALTH CARE
ALARIS DRUG LIBRARY REQUEST FORM**

This form is to be COMPLETED IN DETAIL, LEGIBLY, and submitted to your pharmacist. This form may be submitted by Nurse Managers, Assistant Nurse Managers, Nurse Educators, and Pharmacists.

Please check one or both:

Request for Alaris Addition

A request to add an IV medication to your Alaris IV pump.

Request for a guardrails or product change

A request for a change to an IV medication already on your Alaris IV pump.

Please complete the following. Contact the Alaris Clinical Informatics Specialist at AlarisFeedback@vtmednet.org if assistance is needed filling out the request.

A. Generic Name:

Brand Name:

B. Is this a continuous or intermittent IV medication? CONTINUOUS INTERMITTENT

C. List the product strength and bag volumes if known:

D. Reason why this drug or change should be added to Alaris:

E. What is the priority of this request (Are there safety considerations)? ROUTINE (1 Month) URGENT (1 Week)

F. What is the usual route of administration? CENTRAL PERIPHERAL BOTH

G. Usual doses and infusion rates at which this medication is administered:

H. Will different dosing protocols be needed? If yes, specify the protocols:

I. Comments:

Date requested _____ Requested by (signature) _____

Phone _____ Print name _____

Nursing unit/clinic/procedure area _____ Title _____

Profile used by your area:

CRITICAL CARE MED SURG NICU OB/L&D PEDS