Children's Oncology Services, Inc.
Port-a-Cath/Broviac/Central Line Catheter

For office use only:

Name

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PLEASE fill out ALL pages of the application COMPLETELY and PRINT CLEARLY

To be completed by the PHYSICIAN / NURSE PRACTITIONER and returned with application.
* * Application will **NOT** be processed without this form or without the appropriate signature. * *

Child's name _____ -- --
First MI Last Exam date (Mo – Day - Yr)

Child has a port-a-cath. Yes No

Child has a Broviac/central line catheter. Yes No

Fill out the following ONLY if you answered YES to the previous statement.

Does this child do his/her own central line care (flushing, dressing)? Yes No

Single/Double Lumen _____

How often is it flushed? _____ What days of the week? _____ Flush AM / PM

When is dressing changed? _____

When is cap changed? (day of week) _____ AM / PM

☐ Heparin 100 units / ml How many cc's of flush are used? _____

☐ Vancomycin / heparin

This child has my permission to take a shower. Yes No

This child has my permission to swim in a chlorine-treated swimming pool or hot tub. Yes No

Physician approval for swimming in pool or hot tub: Yes No

Physician/ Nurse Practitioner signature -- --
Date (Mo – Day - Yr)

Parent/Guardian reviewed: _____
Initials

* * * * * Application will **NOT** be processed without this form or without a doctor's signature. * * * * *