Appendix A:

Request for Infusion Pump Drug Library Updates

Date of Request: _____

Change Requested by _____

Approval granted by Chairman of Departmental Committee: _____
Approval Date: _____

Summary of Change(s)_____

Change Requested due to:

___ Change in Evidence Based Practice
___ Change in our Clinical Practice
___ Change required for Patient Safety
___ Change in Regulatory Practice

Care Area: _____ Drug Name: _____

Type of Request: ☐ Addition ☐ Deletion ☐ Change

Issue/Concern: _____

Current Setting: _____

Requested Change: _____

Rationale: _____

Priority of Request: ☐ High ☐ Low

Please complete the above information and send to the designated individual for development and maintenance of Infusion Pump Drug Library.

Notes: *(to be completed by Pharmacy Information Systems)*
Date Request Received: _____; Date of Committee approvals: _____