Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_

Primary Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_

Secondary Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_

Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(PLEASE ATTACH LAST CHART NOTE)** **(PLEASE ATTACH COPY OF INSURANCE)**

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD 10 Code (s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 1 – Clinical** (*Must be completed to initiate services with Infusion Care, LLC and facilitate insurance authorization.)*

* NKDA Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_ cm / inches Weight: \_\_\_\_\_\_\_\_ kg / lbs. Male Female

This is the first dose: Yes  No If no, list product: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last infusion date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ Next dose due: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_

Line Type: PIV PICC Port Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(PLEASE ATTACH PICC REFERRAL FORM IF PICC PLACEMENT IS REQUESTED)**

**Section 2 – Medication**

|  |  |
| --- | --- |
| **Medication:** | **Dose:** |
| **Directions:**  **Infuse IV per manufacturer guidelines**  **Other:** | **Quantity / Refills**  **Dispense 1-month supply on all selected medications**  **Refill 12 months unless otherwise noted**  **Other:** |

**Section 3 – Pre-Medication**

RN to start peripheral IV or use existing CVC

Pre-medication will be given 30 minutes prior to infusion *(Medications will not be administered unless checked.)*

Diphenhydramine: 25 / 50 mg PO ***OR*** 50 mg IV diluted in D5W, or NS 50-100 mL infused over 15 minutes

Antihistamine: Fexofenadine 180 mg PO **OR** Cetirizine 10 mg PO

Solu-medrol: 125 mg IV push over 5 minutes **OR** \_\_\_\_\_\_\_ mg slow IV push over 5 minutes

Acetaminophen: 325 – 650 mg PO **OR** \_\_\_\_\_\_\_ mg PO

Other Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 4 – Reaction Medications**

*(Medications only to be dispensed during adverse reaction event. These orders will be followed, and physician will be notified immediately)*

* Discontinue Infusion. Infuse D5W or NS at 20 mL/hour KVO. May increase to 100-250 mL/hour for hydration.
* Follow Infusion Care Facility Adverse Reaction Protocol, copy of same available upon request.
* RN may administer the following if discontinuing infusion does not resolve symptoms:

Diphenhydramine 50 mg IV diluted in D5W or NS 50-100 mL over 15 minutes **OR** 50 mg / 10 mL NS IV push over 3 minutes, as tolerated.

Methylprednisolone 125 mg **OR** \_\_\_\_\_\_\_ mg slow IV push over 5 minutes.

Acetaminophen 325-650 mg PO **OR** \_\_\_\_\_\_\_ mg PO at onset of symptoms.

Ondansetron 4 mg slow IV push over 5 minutes **OR** 4 mg ODT.

Epinephrine (EpiPen Auto-Injector) as directed by patient weight per IM or SQ route during anaphylactic reaction. May repeat once.

*(911 emergency medical services will be contacted if utilized.)*

**Section 5 – Provider Information**

Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_ Fax: (\_\_\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State**:**  Nevada Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_

License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DEA Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_