

Infusion Care, LLC – Patient Infusion Referral Form

Fax Completed Form to (702) 998-4445



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: <input type="checkbox"/> Infuse IV per manufacturer guidelines <input type="checkbox"/> Other: _____	Quantity / Refills <input type="checkbox"/> Dispense 1-month supply on all selected medications <input type="checkbox"/> Refill 12 months unless otherwise noted <input type="checkbox"/> 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: ____/____/____

Infusion Care, LLC
 8530 W. Sunset Road Suite 330
 Las Vegas, NV 89113
 (702) 998-VVIC (8842)

6502 S. McCarran Blvd, Ste B
 Reno, NV 89509
 (775) 470-NNIC (6642)