Infusion Care, LLC – Patient Infusion Referral Form

Fax Completed Form to (702) 998-4445

Patient Name: ______________________________ Date of Birth: ____/____/________
SSN: ______ - ____ - ________ Primary Phone: (______) ______ - ________
Address: ______________________________ 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 Vegas Valley Infusion Centers, 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.

☐ 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

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