

Home Infusion Referral Form

Patient Information

Patient Name	Date of Birth	Weight (required) kg lbs	Height (required) ft in
Address	City State Zip		
Male Female	Diabetic: No Yes	Allergies	
Parent/Guardian Name (if applicable)			

Medical Information

Primary Diagnosis	ICD-10 Code
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Prescription and Orders

Medication	Dose	Frequency	Duration

Pharmacy to dose based on current lab results? No Yes

1. IV Access:
PICC Lines: _____
 Weekly dressing changes unless integrity of dressing changes or becomes soiled. Securing device to be used unless line is sutured in. Flush with 10mL NS before and after each use and weekly when not in use. If administering TPN or drawing labs flush with 20mL NS after use. May use 5mL Heparin flush 100 unit/mL for sluggish line. Use only 10mL syringe or larger.

_____ **Midline Catheter:**
 Weekly dressing changes unless integrity of dressing changes or becomes soiled. Securing device to be used unless line is sutured in. Flush with 10mL NS before and after each use and weekly when not in use. If administering TPN or drawing labs flush with 20mL NS after use. May use 5mL Heparin flush 100 unit/mL for sluggish line. Use only 10mL syringe or larger.

_____ **Peripheral IV:**
 Dressing change at site rotation every 72-96 hours or when clinically indicated. Flush with 5-10mL NS before and after each use. May use 3mL Heparin flush 10 unit/mL.
 Other: _____

2. Anaphylaxis Protocol:
 Epinephrine 0.3mg IM / Diphenhydramine 25-50mg by mouth PRN.

3. Labs Needed: _____
 Frequency of Labs: _____ or Labs Per Pharmacy Protocol

- 4.** Pull IV access when therapy is complete.
- 5.** May discharge patient when therapy is complete.

Physician Information

Physician Name	Home Health Agency
Address City State Zip	Main Phone Office Contact
NPI # DEA # License #	Phone Alternate Phone Fax Email
All Insurance Info Attached <input type="checkbox"/> No <input type="checkbox"/> Yes	

I authorize Fannin Infusion Pharmacy and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Fannin Infusion Pharmacy.

Physician Signature: _____
 Date: _____

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

The attached document(s) contain confidential information which may be considered to be Protected Health Information and therefore required to be maintained as private and secure under HIPAA. The documents may also contain information which is otherwise considered to be privileged under state and federal laws. This communication is for the intended recipient only. If you are not the intended recipient, or a person responsible for delivering this communication to the intended recipient, you are prohibited from viewing, copying and/or distributing the information contained herein. Unlawful disclosure of the information attached may subject you to monetary penalties and sanctions. If you have received this communication in error, you should notify the sender immediately and thereafter permanently destroy all copies of this document in its entirety.

This form is not considered an order or prescription for medical services and/or supplies unless and until it is formally authorized by a healthcare provider in compliance with applicable laws and regulations.

This is not a valid prescription in the state of Arizona.

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