

Pharmacy Name: _____ Phone: _____
 Address: _____ Fax: _____
 City/State/Zip: _____ Email: _____

IV Antibiotic Referral Form

To	From
Intake Number	Phone
Date	Number of Pages including Cover
Patient Name	DOB
Lumen Number on Access	
Diagnosis/ICD-10	Allergies
Start of Care Date	
Will nursing be required?	How many visits/hours?
Length of need	Refills

Initiation/Continuation of infusion therapy orders (drug, dose, rate, duration and frequency):

1. _____
2. _____
3. _____
4. _____

Supplies/Pump/Pole as appropriate to administer ordered therapy:

Anaphylaxis Kit: Epi Vial EpiPen Auto-injector use as directed. 2 Pak Kit PRN, refill x 1 year

Laboratory Orders:

Additional Comments/Orders

Prescriber Signature _____	Date _____
Print Prescriber Name _____	NPI# _____

Please fax the following information:

Patient Demographics - include insurance information. We will obtain authorization unless the insurance dictates otherwise

H & P OR progress note(s) describing diagnosis and clinical status

Recent Laboratory Results

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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