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