IV Antibiotic Therapy - Home Infusion Referral Form

Please complete the attached form with current labs and relevant history, then fax it to the appropriate One Care Infusion Pharmacy location based on the patient's location

Hospital/Clinic Name: _____ **Hospital Location:** _____
Referral Contact Name: _____ **Phone:** _____ **Fax:** _____

Patient Name: _____ **DOB:** _____ **Gender:** ☐ **M** ☐ **F** ☐ _____
Address: _____ **Parent/Guardian:** _____
_____ **Home Phone:** _____
City: _____ **State:** _____ **Zip:** _____ **Cell Phone:** _____

Insurance: *Provide the following or attach photocopy of front and back of card if available/PRC approval.*

Primary Insurance	Secondary Insurance
Insurance Company: _____	Insurance Company: _____
ID Number: _____	ID Number: _____
Patient Relationship to Cardholder: _____	Patient Relationship to Cardholder: _____
Phone Number: _____	Phone Number: _____

Primary ICD-10: _____ **Height:** _____ **IV Access Type:** _____
Secondary ICD-10: _____ **Weight:** _____ **Date Placed:** _____
Allergies: _____ **# of Lumen:** ☐ 1 ☐ 2 ☐ 3

	Therapy 1		**Therapy 2**	
Therapy Ordered:	☐ Ceftriaxone ☐ Cefepime ☐ Daptomycin ☐ Other: _____	Dose: _____ Frequency: _____ Start Date: _____ Duration/Stop Date: _____	☐ Ceftriaxone ☐ Cefepime ☐ Daptomycin ☐ Other: _____	Dose: _____ Frequency: _____ Start Date: _____ Duration/Stop Date: _____
Labs:	☐ BMP ☐ CBC w/ differential Q week ☐ Trough ☐ Sed rate ☐ Other: _____		Weekly: ☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat Name of Lab: _____ Lab Fax: _____	
Flush:	☐ NS 10mL flush b/a Q infusion and PRN ☐ **Q24H Infusion:** Heparin (yellow) **100** unit/mL x 5mL Q infusion ☐ Heparin (blue) **10** unit/mL x 5mL Q infusion ☐ Do **NOT** use Heparin		Dressing change/at home nursing care provided by: _____ Latest dressing change date: _____	

Following Physician: _____ Phone: _____

Anticipated Discharge: Date- _____ **Estimated Time-** _____

Prescriber's Name: _____ **NPI:** _____ **Phone:** _____

Prescriber's Signature: _____ **Date:** _____ **Fax:** _____

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