PharmaScript Ambulatory Infusion Center
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Infusion Referral Form

Patient Name: ____ SSN#: ____________________ Phone#: ____________________________

Address: _______________________________________ APT#: _______ City: ________________ State: _____ Zip Code: _____________

DOB: ________________ HT: ________ WT: _________ Emergency Contact: ________________________ Phone #: ________________

Allergies: ____________________________________ Diagnosis: ____

Primary Insurance Carrier:____________________________ Primary Insurance Phone#: ___________________________

Card Holder ID: ______________________________ Group#: ____________________________________ (Please Attach Copy of Card)

Line Type: [] Peripheral [] Port [] SL PICC [] DL PICC [] CVL *(Please attach placement paperwork)*

Prescriber: _________________________________ Office: ____________________________ Contact: ______________________________

Office Address: _______________________________________ City: __________________ State: _______ Zip Code: __________________

Phone: _______________________ Fax: ______________________ NPI#: ______________________ DEA#: ___________________________

Prescriber Signature: _______________________________________ Date: _____________ Start of Care Date: _________________________

(Please note for Insurance compliance the prescribing physician must sign Rx, no stamps or nurse signatures)

MEDICATION/s	DOSAGE	ROUTE	FREQUENCY

☐ Saline flush per Pharmacy protocol ☐ Heparin flush (10 U/ml, if pedia; 100 U/ml, if adult): 5 ml at end of SASH☐ Other: Cathflo PRN

***Pre-Medications*: (medications in this section are a single dose prior to IV administration or other meds, unless otherwise indicated)**

- ☐ Acetaminophen 650 mg P.O
- ☐ Acetaminophen 1000 mg P.O
- ☐ Diphenhydramine 25 mg ☐ PO ☐ IV
- ☐ Diphenhydramine 50 mg ☐ PO ☐ IV
- ☐ Hydrocortisone (Solu-cortef) ______ mg IV
- ☐ Methylprednisolone (Solu-Medrol) ______ mg IV
- Cetirizine HCI (Quzyttir) ______mg IV
- Other: ____________________________________

***PRN Medications*:**

- ☐ Diphenhydramine HCl _______ mg IV x 1 PRN for infusion hypersensitivity reactions.
- ☐ Solu-Medrol ______ mg IV x 1 PRN for hypersensitivity reactions.
- ☐ Zofran _____ mg IV x 1 prn nausea
- ☐ Topical Anesthetic cream apply to skin prior to PIV catheter insertion as needed for pain

***Anaphylaxis and ADR Prevention Kit Orders*:**

- ☐ Per Pharmacy protocol (Epinephrine, Diphenhydramine oral/injectable, acetaminophen, NS bag)
- ☐ Oxygen inhalation at ______ liters/min via NC/Face mask

Additional Orders: For CVD, PICC

- ☐ Catheter Care only: Flush access device _________ (frequency) with NS + Heparin to maintain patency.

*****Please attach [] History/Physical, [] Most Recent Labs, and [] Current Medication List*****

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