Home Parenteral Nutrition (PN) referral / Home start order form

Infusion pharmacy

Phone:

Fax:

✂ Please detach before submitting to a pharmacy–tear here.

PATIENT INFORMATION

Acute care specialist: Name: Phone:

Patient: ☐ see attached Gender: ○ Male ○ Female

Patient name: DOB: Last 4 of SSN:

Address: City:

State: ZIP: Phone: Cell:

Emergency contact: Phone: Relationship:

*** IF MEDICARE PLEASE ATTACH/SEND ALL MEDICAL DOCUMENTATION INCLUDING ESTIMATED LENGTH OF NEED FOR PN DOCUMENTED IN MEDICAL RECORD BY ATTENDING PHYSICIAN. NOTE: COVERAGE WITH MEDICARE IS NOT GUARANTEED.**

Desired start date: Home health nursing or preferred agency, if not Optum:

Central access: ○ Yes ○ No | ○ PICC ○ PORT ○ Tunneled catheter Attach documentation

Insurance: ☐ Front and back of insurance card to follow

Primary Insurance: Phone: Policy #: Group:

Secondary Insurance: Phone: Policy #: Group:

PRESCRIPTION AND ORDERS

Required labs: *(CMP, magnesium, phosphorus, CBC with differential)* ○ YES ○ NO

If not, draw above labs PRIOR to initiation of PN Date of labs:

Select the following starting prescription (per 24 hours) for the first days of PN:

○ **1 Liter of Clinimix® E 4.25/5**

50g Dextrose 42.5g Amino acids 35 mEq Sodium 30 mEq Potassium 4.5 mEq Calcium 15 mM Phosphorus
5 mEq Magnesium 10 ml IV MVI 1 ml MTE-Conc 100mg Thiamine

○ **2 Liter of Clinimix® E 4.25/5**

100g Dextrose 85g Amino acids 70 mEq Sodium 60 mEq Potassium 9 mEq Calcium 30 mM Phosphorus
10 mEq Magnesium 10 ml IV MVI 1 ml MTE-Conc 100mg Thiamine

○ **Liter**

g Dextrose g Amino acids mEq Sodium mEq Potassium mEq Calcium mM Phosphorus
mEq Magnesium 10 ml IV MVI 1 ml MTE-Conc 100mg Thiamine

☐ **Nursing/lab orders**

Required labs to be drawn 48 hours after initiation of PN: *(CMP, magnesium, phosphorus)*

Cycle PN: initially at 18 hours with a programmed 1 hour taper up and 1 hour taper down

Flush CVAD: 0.9% Sodium Chloride 10mL before and after infusion. Lock CVAD with Heparin 10units/mL or *(if PORT)* 100units/mL 5mL as a final lock for patency.

Nursing to assess patient, teach PN adminstration, draw lab work, and perform weekly dressing changes
Pharmacy to dispense flushes, syringes, needles, HME/DME, in quantity sufficient to complete prescribed therapy

PHYSICIAN INFORMATION

Name: Practice:

Address: City: State: ZIP:

Phone: Fax: NPI: Contact:

By signing, I certify/recertify that the above therapy, products and services are medically necessary and that this patient is under my care. I have received authorization to release the above referenced information and medical and/or patient information relating to this therapy. Pharmacy has my permission to contact the insurance company on my behalf to obtain authorization for patient.

Please fax: ☐ Completed form ☐ Demographic sheet/insurance information ☐ Clinical notes and lab ☐ TB results

Signature: Date:

This form is not a valid prescription in Arizona.