IV Anti-infectives referral 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: SSN:

Address: City:

State: ZIP: Phone: Cell:

Emergency contact: Phone: Relationship:

Insurance ☐ Front and back of insurance card to follow

Primary Insurance: Phone: Policy #: Group:

Secondary Insurance: Phone: Policy #: Group:

Primary diagnosis ☐ Diagnosis code: ☐ Med list attached

☐ Other:

Medical assessment Height: Weight: ○ lbs ○ kg

Current medications? ○ Yes ○ No If yes, list or attach:

Allergies:

IV access: ☐ PIV ☐ PICC ☐ Port ☐ Midline ☐ Tunneled CVL Number of lumens

PRESCRIPTION ORDERS to be infused per pi recommended rate and via rate controlled device per therapy

Medication Orders

Drug: Dose: Frequency: Start Date: Stop Date: Duration of Therapy:

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IV Access Maintenance

Sodium Chloride 0.9%: Flush each lumen with 5 – 20 ml before and after each medication dose and as needed for lab draws and daily line maintenance if applicable. Flush each lumen of IV access with 5 – 20 ml Sodium Chloride 0.9% on days medication not administered, if applicable.

Heparin 10 units/ml: Flush each lumen with 3-5 ml after each medication dose and as needed for lab draws and daily line maintenance if applicable. [Substitute Heparin 100 units/ml if Port-A-Cath]

Lab Orders

Antibiotic Therapy: ☐ CBC ☐ BMP ☐ CMP ☐ CRP ☐ ESR ☐ CPK ☐ Vanc Trough weekly

Other lab orders:

Additional Orders

☑ Pharmacy to dispense quantity sufficient of all needles, syringes, and IV access supplies medically necessary to provide the prescribed treatment through completion of the therapy.

☑ Skilled RN to provide inpatient bedside education for home infusion antibiotic therapy.

☑ Skilled RN to perform initial home visit for admission assessment, education *(teach & train),* and/or administration of outpatient infusion. RN to provide patient/caregiver education related to medication management, line care, disease state, emergency preparedness, adverse medication effects, home safety, infection control measures, nutrition/hydration, and contact information for physician/pharmacy.

☑ Optum pharmacist to monitor lab values and make therapeutic dose adjustments as needed. Pharmacist may order additional lab work as necessary for therapy monitoring, if permitted by state regulations.

☐ Other:

This form is not a valid prescription in Arizona.

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☑ **Anaphylaxis Kit Order Infusion Reaction Management x1 year**

Mild

• Slow infusion rate by 50% until symptoms resolve. Resume at previous rate as tolerated.

☐ DiphenhydrAMINE PO ○ 25mg ○ 50mg ○ mg Dispense diphenhydrAMINE 25mg capsules x 4

Moderate

☐ Stop Infusion, resume at 50% rate when symptoms resolve

☐ DiphenhydrAMINE IV2 ○ 25mg ○ 50mg ○ mg Dispense diphenhydrAMINE 50mg vial x 1

Severe (Anaphylaxis) *Call 911* Notify prescribing physician

• Stop infusion and remove tubing from access device to prevent further administration

• Initiate 0.9% NaCl 500mL/hr IV OR mL/hr

• **Administer EPINEPHrine 1mg/mL by weight (Wt.) as an IM injection into the lateral thigh**

Wt > 66lbs (30kg)	Wt 33 to 66 lbs (15 to 30kg)	Wt < 33lbs (15kg)
0.3mg/0.3mL	0.15mg/0.15mL	0.01mg/kg

• Repeat EPINEPHrine in 5 to 15 minutes if symptoms persist • Administer CPR if needed until EMS arrive

☑ Dispense 0.9% NaCl 500mL x1 ☑ Dispense EPINEPHrine 1 mg vial x 2

☐ Other medication:

PHYSICIAN INFORMATION

Name: Address:

Practice: City: State: ZIP:

Phone: Fax: NPI: Contact:

Signature: Date:

NOTES

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