IV Anti-infectives referral form

Phone: ____________________

Fax: ____________________

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 AND 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:_________

Drug:___________ Dose:___________ Frequency:__________ Start Date:__________ Stop Date:_________ Duration of Therapy:_________

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: ____

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Patient name: ____ DOB:_______________________

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

[X] **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

[X] Dispense 0.9% NaCl 500mL x1 [X] Dispense EPINEPHrine 1 mg vial x 2

[ ] Other medication: ____

PHYSICIAN INFORMATION

Name:		Address:		
Practice:		City:	State:	ZIP:
Phone:	Fax:	NPI:	Contact:	

Signature: ____ Date: _______________________

NOTES