Infusion Solutions Inc.
Home Infusion & Specialty Pharmacy
477 W. Horton Rd
Bellingham, WA 98226
Phone (360) 933-4892
Fax (360) 933-1197

Infusion Therapy Referral Form

Please fax the following information to **(360) 933-1197** to facilitate a swift and easy referral:

DEMOGRAPHICS

Patient Name: _____ Date of Birth: _____ Gender: ❑F ❑M

Home Phone: _____ Cell: _____ Work: _____

Address: _____

City: _____ State: _____ Zip: _____

Legally Responsible Representative: _____ Relationship to Patient: _____

FINANCIAL INFORMATION

**Please fax a copy of front and back of all insurance cards if available.

Payor: _____ ID#: _____ Group#: _____

Cardholder: _____ ❑ Self ❑ Spouse ❑Child

ORDERS (check boxes to initiate therapy)

Height: _____ **Weight:** _____ **Allergies:** _____

Diagnoses: _____ ICD-10: _____
_____ ICD-10: _____

Medication Orders:

- ❑ Medication/Dose: _____ Route: ❑IV ❑SQ ❑Other: _____
  Instructions: _____ Duration of therapy: _____ ❑TBD (≤1 yr)
- ❑ Medication/Dose: _____ Route: ❑IV ❑SQ ❑Other: _____
  Instructions: _____ Duration of therapy: _____ ❑TBD (≤1 yr)
- ❑ Clinical pharmacist to monitor drug levels and adjust dose accordingly
- ◆ Alteplase 2mg IV to declot central IV access per Infusion Solutions protocol as needed for occlusion.
- ◆ Flush line with D5W, 0.9% NaCl and/or Heparin 10 units/ml or 100 units/ml per Infusion Solutions protocol.
- ◆ Lidocaine 1% - up to 0.2ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).
- ◆ Infusion Reaction Management per Infusion Solutions protocol as needed.

Nursing Orders:

- ◆ If no central IV access, RN to insert peripheral IV, rotate site every 72 to 120 hours or as needed.
- ❑ Other: _____

Lab Orders:

- ❑ _____ ❑ One time ❑ weekly ❑ every _____
- ❑ _____ ❑ One time ❑ weekly ❑ every _____

_____ _____
Prescriber Signature *Date*

_____
Please Print Name