

600 Whitney Ranch Drive Suite C14,15 Phone: 702-476-6996

Henderson, NV 89014 Fax: 702-476-6766

[www.lasvegasinfusion.com](http://www.lasvegasinfusion.com)

**INOTROPE REFERRAL REQUEST**

(referral requests maybe be filled online)

Page 1 of 2

Name of person supplying referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Information: (office telephone number) \_\_\_\_\_\_\_\_\_\_\_\_\_ (cell phone/pager): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital/Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Room#: \_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_

Discharge Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expected Start Date of Home Infusion: \_\_\_\_\_\_\_\_\_\_\_

Is patient aware of referral to Las Vegas Infusion Pharmacy? □ Yes □ No

DEMOGRAPHICS

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS #: \_\_\_\_\_\_\_\_\_\_ MR#: \_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_

Primary Tel Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell/Home) Secondary Tel Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(C/H/W)

Primary Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Following Physician and Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE (please fax a copy of all insurance cards if available)

Payor 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Payor 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLINICAL INFORMATION

Primary Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD-10: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD-10: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_Weight: \_\_\_\_\_\_\_\_\_\_ Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ORDERS:

|  |  |  |
| --- | --- | --- |
| **Medication** | **Dose** | **Duration** |
| □Dobutamine□Milrinone□Dopamine | \_\_\_\_\_\_\_\_\_\_mcg/kg/min\_\_\_\_\_\_\_\_\_\_kg(dosing weight) | □Continuous□Intermittent | \_\_\_\_\_hours/day\_\_\_\_\_day/week ***OR***every \_\_\_\_\_ days |
| **Labs:** | □CBC □CMP □BNP □Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Refills: \_\_\_\_\_\_\_\_\_\_\_\_\_ |

Access: □Hickman □Groshong □PICC □Port other: \_\_\_\_\_\_\_

□Flush line with NS and/or Heparin per Las Vegas Infusion Pharmacy protocol

□Alteplase 2mg IV; leave in catheter for 1 hour; if still occluded, may repeat dose x1

□Nitrogen Patch \_\_\_mg #4; in case of infiltration/extravasation, place 1 patch near insertion site

HOME HEALTH AGENCY (if no agency is specified, use Las Vegas Infusion Pharmacy nursing)

Agency Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel Number: \_\_\_\_\_\_\_\_\_\_\_\_ Contact: \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescriber Signature above printed Name Date



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Page21 of 2

**HOME PARENTERAL INOTROPIC THERAPY: DATA COLLECTION FORM**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_ HIC number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information below may not be completed by the supplier nor anyone in a financial relationship with the supplier.

1. Results of invasive hemodynamic monitoring

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Cardiac Index** | **Wedge Pressure** | **Date** |
| Before Inotrope Infusion |  |  |  |
| On Inotrope Infusion |  |  |  |
| Drug Name:  | Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_mcg/kg/min |

2. Cardiac drugs (digoxin, diuretics, vasodilators) immediately prior to inotrope infusion (list name, dose, frequency): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Does this represent maximum tolerated doses of these drug?

4. Breathing status (check one in each column)

|  |  |  |
| --- | --- | --- |
|  | **Prior to Inotrope Infusion** | **At time of discharge** |
| No dyspnea on exertion |  |  |
| Dyspnea on moderate exertion |  |  |
| Dyspnea on mild exertion |  |  |
| Dyspnea at rest |  |  |

5. Initial home prescription: Drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_mcg/kg/min

 \_\_\_\_\_hours/day \_\_\_\_\_day/week (OR every \_\_\_\_\_ days)

6. If continuous infusion is prescribed, have attempts to discontinue inotrope infusion in the hospital failed? \_\_\_\_\_\_\_\_\_\_

7. If intermittent infusion is prescribed, have there been repeated hospitalizations for heart failure during which parenteral inotropes were required? \_\_\_\_\_\_\_\_\_\_

8. Is routine electrocardiographic monitoring required in the home? \_\_\_\_\_\_\_\_\_\_

The above statements and any additional explanations included separately are true and accurate and there is documentation present in the patient’s medical record to support these statements.

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name Printed/Typed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ UPIN #: \_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_