

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)

**PARENTERAL NUTRITION REFERRAL REQUEST**

(referral requests maybe be filled online)

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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: \_\_\_\_\_\_\_\_\_\_ Allergy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ORDERS:

□Parenteral Nutrition per LVIP clinical pharmacist (initial formulation, continued adjustments and labs)

Order baseline labs if most recent is older than 3 days

□Continue discharging hospital’s order for 3 days OR \_\_\_ days, then LVIP clinical pharmacist to adjust based on patient’s clinical response and laboratory results; pharmacist to order labs

□I am providing the initial formula for 3 days OR \_\_\_ days, then LVIP clinical pharmacist to adjust based on patient’s clinical response and laboratory results; pharmacist to order labs

□I am providing formula and will order labs and monitor this PN therapy

|  |  |  |  |
| --- | --- | --- | --- |
| Lab Orders | | | Blood Glucose |
| □CBC with diff | □Once □Twice(M&F) weekly | □Every \_\_\_\_\_\_\_\_\_\_ | □Twice daily (continuous) |
| □CMP | □Once □Twice(M&F) weekly | □Every \_\_\_\_\_\_\_\_\_\_ | □1 hour before infusion (cyclic) |
| □Magnesium | □Once □Twice(M&F) weekly | □Every \_\_\_\_\_\_\_\_\_\_ |
| □Phosphorous | □Once □Twice(M&F) weekly | □Every \_\_\_\_\_\_\_\_\_\_ | □with routine labs (stable) |
| □Pre-albumin | □Once □Twice(M&F) weekly | □Every \_\_\_\_\_\_\_\_\_\_ |
| □Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □Once □Twice(M&F) weekly | □Every \_\_\_\_\_\_\_\_\_\_ | □Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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

Prescriber Signature above printed Name Date



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

TPN Order:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Macronutrients** | | | | | | |
| Clinimix 5/15 2000mL  (Amino Acids 5%-Dextrose 15%) | | Clinimix 4.25/10 2000mL  (Amino Acid 4.25%-Dextrose 15%) | | | Other  Amino Acids (4kcal/gram): \_\_\_\_\_\_%  Dextrose (3.4kcal/gram): \_\_\_\_\_\_%  Total Volume (without Lipids): \_\_\_\_\_\_mL | |
| **Lipids 20%** | | | | | | |
| □250mL/day = 500kcal | □Other: \_\_\_\_\_\_mL/day | | | Frequency: □Daily □3x/week □\_\_\_\_\_\_times/week | | |
| **Electrolytes** | | | | | | |
| □Sodium (1-2mEq/kg): \_\_\_mEq | | | □Potassium (0.5-2mEq/kg): \_\_\_\_\_mEq | | | □Chloride (to balance – standard = 1:1): \_\_\_\_\_mEq |
| □Acetate (to balance – standard = 1:1): \_\_\_\_\_mEq | | | □Calcium (5 – 15mEq):  \_\_\_\_\_mEq | | | □Magnesium (8 – 20mEq): \_\_\_\_\_mEq |
| □Phosphorous (15 – 40mmol): \_\_\_\_\_mmol | | | | | | |
| **Vitamin Additives** | | | | | | |
| □Cyanocobalamin (B12): 1mg | | | □Folic Acid: 5mg | | | □Multivitamins 10mL\* |
| □Pyridoxine (B6): 100mg | | | □Thiamine (B1): 100mg | | | □Vitamin K: 1mg |
| □Ascorbic Acid/Vitamin C (500-1000mg): \_\_\_\_\_mg | | | | | | |
| **Other Additives** | | | | | | |
| □Famotidine: \_\_\_\_\_mg | | | □Insulin: \_\_\_\_\_units | | | □Selenium\*\*/\*\*\*: 40mcg |
| □Zinc\*\*/\*\*\*: 5mg | | | □Trace Elements – 4\*\*: 1mL ***OR*** □Trace Elements – 5\*\*\*: 1mL | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***\*Infuvite/10mL*** | | Vitamin B12 (Cyanocobalamin) | 5mcg | ***Trace Elements-4\*\**** | |
| Vitamin A | 1mg (3,300 IU) | Vitamin C | 200mg | Chromium | 10mcg |
| Vitamin B1 (Thiamine) | 6mg | Vitamin D | 5mcg (200 IU) | Copper | 1mg |
| Vitamin B2 (Riboflavin) | 3.6mg | Vitamin E | 10mg (10 IU) | Manganese | 0.5mg |
| Vitamin B3 (Niacin) | 40mg | Vitamin K | 150mcg | Zinc | 5mg |
| Vitamin B5 (Pantothenic Acid) | 15mg | Biotin | 60mcg | ***Trace Elements-5\*\*\* (same as above) plus*** | |
| Vitamin B6 (Pyridoxine) | 6mg | Folic Acid | 600mcg | Selenium | 60mcg |

□Cyclic TPN: Infuse over \_\_\_\_\_\_\_\_\_\_ hours (taper x2 hours up and down according to protocol)

□Continuous TPN (24 hours/day)

Catheter Maintenance:

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

□Anaphylaxis kit per Las Vegas Infusion Pharmacy protocol

□Alteplase 2mg IV; leave in catheter for up to 2 hours; if still occluded, may repeat dose x1

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