

600 Whitney Ranch Drive Suite C14,15

Henderson, NV 89014

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

Phone 702-476-6996

Fax 702-476-6766

**METHYLPREDNISOLONE S.S. (Solu-Medrol®)REFERRAL REQUEST**

(referral requests maybe be filled online)

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:

|  |
| --- |
| □Solu-Medrol® □500mg □1gram IV QD for 3 days |
| □Solu-Medrol® \_\_\_\_\_mg IV every \_\_\_\_\_\_\_\_\_\_ for \_\_\_\_\_ days |
| Other: |

Received first dose: □Yes □No

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

□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

□may start peripheral IV access, rotate sites every 3-4 days or PRN

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