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

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

**Henderson, NV 89014 Fax: 702-476-6766**

**ANTI-INFECTIVE 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:

|  |  |
| --- | --- |
| Anti-Infective Order #1 | Anti-Infective Order #2 |
| Drug:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Frequency: \_\_\_\_\_\_\_\_\_Start Date: \_\_\_\_\_\_\_\_\_Duration: \_\_\_\_\_\_\_\_\_\_ | Drug:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dose:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Frequency: \_\_\_\_\_\_\_\_\_Start Date: \_\_\_\_\_\_\_\_\_Duration: \_\_\_\_\_\_\_\_\_\_ |
| Labs: | \_\_CBC with diff \_\_weekly or every \_\_\_\_\_\_\_\_\_\_\_\_ESR \_\_weekly or every\_\_\_\_\_\_\_\_\_\_\_\_BMP \_\_weekly or every\_\_\_\_\_\_\_\_\_\_\_\_CMP \_\_weekly or every\_\_\_\_\_\_\_\_\_\_\_\_Hepatic Panel \_\_weekly or every\_\_\_\_\_\_\_\_\_\_\_\_CRP \_\_weekly or every\_\_\_\_\_\_\_\_\_\_  | \_\_Vancomycin order: draw trough prior to **\_\_\_\_\_\_dose** and pharmacy to adjust as needed and order further levels\_\_Aminoglycoside order: draw peak & trough around **\_\_\_\_\_\_dose** and pharmacy to adjust as needed and order further levels |

Received first dose: □Yes □No

Access: □IM □SQ □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