



**PharmaScript Ambulatory Infusion Center**  
**6501 Americas Parkway NE, Suite 121 Albuquerque, NM 87110**  
**Phone: 505.407.2560 fax: 505.859.4013 eFax: 312.277.9575**

**Infusion Referral Form**

Patient Name: \_\_\_\_\_ SSN#: \_\_\_\_\_ Phone#: \_\_\_\_\_  
 Address: \_\_\_\_\_ APT#: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 DOB: \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Allergies: \_\_\_\_\_ Diagnosis: \_\_\_\_\_  
 Primary Insurance Carrier: \_\_\_\_\_ Primary Insurance Phone#: \_\_\_\_\_  
 Card Holder ID: \_\_\_\_\_ Group#: \_\_\_\_\_ (Please Attach Copy of Card)

**Line Type:**  Peripheral  Port  SL PICC  DL PICC  CVL *(Please attach placement paperwork)*

Prescriber: \_\_\_\_\_ Office: \_\_\_\_\_ Contact: \_\_\_\_\_  
 Office Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ NPI#: \_\_\_\_\_ DEA#: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Start of Care Date: \_\_\_\_\_  
*(Please note for Insurance compliance the prescribing physician must sign Rx, no stamps or nurse signatures)*

MEDICATION/s	DOSAGE	ROUTE	FREQUENCY

Saline flush per Pharmacy protocol  Heparin flush (10 U/ml, if pedia; 100 U/ml, if adult): 5 ml at end of SASH  Other: Cathflo PRN

**Pre-Medications: (medications in this section are a single dose prior to IV administration or other meds, unless otherwise indicated)**

- |  |   |
|--|---|
| <input type="checkbox"/> Acetaminophen 650 mg P.O  | <input type="checkbox"/> Hydrocortisone (Solu-cortef) _____ mg IV     |
| <input type="checkbox"/> Acetaminophen 1000 mg P.O   | <input type="checkbox"/> Methylprednisolone (Solu-Medrol) _____ mg IV |
| <input type="checkbox"/> Diphenhydramine 25 mg <input type="checkbox"/> PO <input type="checkbox"/> IV | <input type="checkbox"/> Other: _____                                 |
| <input type="checkbox"/> Diphenhydramine 50 mg <input type="checkbox"/> PO <input type="checkbox"/> IV | _____   |

**PRN Medications:**

- Diphenhydramine HCl \_\_\_\_\_ mg IV x 1 PRN for infusion hypersensitivity reactions.
- Solu-Medrol \_\_\_\_\_ mg IV x 1 PRN for hypersensitivity reactions.
- Zofran \_\_\_\_\_ mg IV x 1 prn nausea
- Topical Anesthetic cream apply to skin prior to PIV catheter insertion as needed for pain

**Anaphylaxis and ADR Prevention Kit Orders:**

- Per Pharmacy protocol (Epinephrine, Diphenhydramine oral/injectable, acetaminophen, NS bag)
- Oxygen inhalation at \_\_\_\_\_ liters/min via NC/Face mask

**Additional Orders: For CVD, PICC**

- Catheter Care only: Flush access device \_\_\_\_\_ (frequency) with NS + Heparin to maintain patency.

\*\*\*\*\*Please attach  History/Physical,  Most Recent Labs, and  Current Medication List\*\*\*\*\*

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