

PharmaScript Ambulatory Infusion Center
Chicago Main Headquarters
Phone: 844.635.3221 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

Flushing Orders:

- Normal Saline 0.9% up to 10mL SAS Protocol.
- Heparin (10 U/mL if pediatric, 100 U/mL if adult): 5mL at end of SASH Protocol.
- Other: Cathflo as needed.

PRN Medications:

- Acetaminophen 650 mg P.O.
- Acetaminophen 1000 mg P.O.
- Diphenhydramine 25 mg PO IV
- Diphenhydramine 50 mg PO IV
- Hydrocortisone (Solu-cortef) _____ mg _____ IV
- Methylprednisolone (Solu-Medrol) _____ mg _____ IV
- Other: _____
- 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:

- Convert to catheter care if infusion therapy is complete and access lines needs to be maintained. Flush each lumen daily with Normal Saline + Heparin

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

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