InfuCare Rx

Parenteral Nutrition (PN) Referral Form

of Pages Faxed: _____
Fax Referral To: 877-828-3941
Phone: 877-828-3940

Date Required: _____ Ship To: ☐ Home ☐ Office ☐ Other: _____

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Alternate Phone: _____
Date of Birth: _____
Email: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA #: _____ NPI #: _____
Contact Person: _____
Email: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____ ID: _____ Group: _____
Secondary Insurance: _____ ID: _____ Group: _____
Prescription Card: _____ ID: _____ BIN: _____ PCN: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

☐ Malabsorption ☐ Malnutrition
Detailed History, TPN orders, Nutrition Consultation/Assessment
Diagnostic Reports (Operation Reports, CT Scan & Fistulagram)
☐ Weight Changes: _____

☐ Patient demographics, including insurance information
☐ Labs – (CMP, CBC with diff, TG, Prealbumin, Mg, Phos, CRP)
☐ H&P and MD consults
☐ Please attach original prescription orders

PN DIAGNOSIS

☐ K56.60 Bowel Obstruction
☐ K95 Complications of Bariatric Procedures
☐ K50 Crohn's Disease
☐ K63.2 Enterocutaneous Fistula
☐ K31.84 Gastroparesis
☐ O21.1 Hyperemesis Gravidarum
☐ K90 Malabsorption
☐ K86.1 Pancreatitis
☐ K91.2 Small Bowel Syndrome
☐ Other: _____

PATIENT EVALUATION

Has patient previously received TPN? ☐ Yes ☐ No
Patient Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in
Allergies: _____
Delivery Method: ☐ Infusion Pump ☐ Other: _____

Line Access:
☐ Hickman ☐ Broviac ☐ Groshong ☐ Port ☐ PICC

Therapy Start Date: _____ Therapy End Date: _____
Nursing Coordination:
☐ Pharmacy to coordinate home health nursing visit as necessary: ☐ Yes ☐ No

PRESCRIPTION INFORMATION – Consult InfuCare Rx RD for Nutritional Recommendations

Sodium Chloride: _____ mEq/day
Sodium Acetate: _____ mEq/day
Sodium Phosphate: _____ mmol/day
Potassium Chloride: _____ mEq/day
Potassium Acetate: _____ mEq/day
Potassium Phosphate: _____ mmol/day
Magnesium Sulfate: _____ mEq/day

Calcium Gluconate: _____ mEq/day
Multivitamin: MVI Adult: _____ mL/day
Trace Elements-MTE 5 Concentrate: _____ mL/day
Regular Insulin: _____ units/day
Other: _____

Amino Acids: _____ grams/day
Dextrose: _____ grams/day
Lipids: _____ grams/day
Total Volume: _____ mL/day
Infuse Over: _____ hours/day
Infuse: _____ days/week
Total Calories: _____ Kcal/day

Additional Medications & Supplies

☐ Anaphylaxis Kit orders as per protocol
☐ Catheter Care Maintenance
☐ Glucometer
☐ Lactated Ringers PRN _____ Quantity/Week
☐ Hydration Bags PRN _____ Quantity/Week
☐ Ethanol Locks
☐ Scale
☐ Weekly Dressing Changes
☐ Weekly Blood Work

ADDITIONAL ORDERS

Prescriber Signature: _____ **Date:** _____ **UPIN:** _____