InfuCare Rx

Anti-Infective Referral Form

of Pages Faxed:______________
Fax Referral To: 877-277-9155
Phone: 877-828-3940

Date Required:__________________ Ship To: ☐ Patient ☐ MD Office ☐ Other: ______________

PATIENT INFORMATION

Patient Name: ______________________
Address: ______________________
City, State, Zip: ______________________
Home Phone: ______________________
Cell Phone: ______________________
Date of Birth: ______________ ☐ Male ☐ Female
Emergency Contact: ______________ Phone: ______________

PRESCRIBER INFORMATION

Prescriber Name: ______________________
Address: ______________________
City, State, Zip: ______________________
Phone: ______________________
Fax: ______________________
DEA #: ______________ NPI #: ______________
Contact Person: ______________________

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:

PATIENT DIAGNOSIS/CLINICAL INFORMATION

☐ L08.9 Skin Infection
☐ M86.9 Osteomyelitis
☐ L03.90 Cellulitis
☐ N39.0 UTI
☐ A49.9 Bacterial infection unspecified
☐ E84.9 Cystic Fibrosis
☐ J06.9 Respiratory Infection
☐ Other: ______________________

Route: ☐ PICC Line ☐ Midline ☐ Tunnelled PICC ☐ Port ☐ Peripheral
Weight: ________ ☐ kg ☐ lbs Height: ________ ☐ cm ☐ in %BSA: ______
Allergies: ______________________ ☐ NKDA
Site of Care: ☐ Home ☐ MD Office ☐ Infusion Suite ☐ Other: ______________
Lab Orders: CBC w/ diff: ________ CMP: ________ ESR: ________
CRP: ________ CPK: ________ Misc: ________
☐ VANCOMYCIN trough to be drawn ______________________

PRESCRIPTION INFORMATION

Medication:	Dose/Strength:	Directions:	Duration of Therapy:	End of Therapy:
☐ CEFAZOLIN (Ancef)	☐ 1gm ☐ 2gm ☐ 6gm	☐ Q__________ ☐ Continuous __________		
☐ CEFEPIME (Maxipime)	☐ _____gm	☐ Q__________		
☐ CEFTRIAXONE (Rocephin)	☐ 1gm ☐ 2gm	☐ Q__________		
☐ CLINDAMYCIN	☐ 300mg	☐ Q__________		
☐ DAPTOMYCIN (Cubicin)	☐ ______ mg per kg daily			
☐ ERTAPENEM (Invanz)	☐ 500mg ☐ 1g	☐ Q24		
☐ MEROPENEM (Merrem)	☐ ______mg ☐ ______g	☐ Q__________		
☐ UNASYN	☐ 1.5gm ☐ 3gm	☐ Q__________		
☐ VANCOMYCN	☐ ______mg ☐ ______g	☐ Q__________		
☐ ZOSYN	☐ 2.25g ☐ 3.375g ☐ 4.5g ☐ 13.5g	☐ Q__________ ☐ Continuous __________		
☐ Other:______________				
☐ Other:______________				

Pre-Medications & Other Medications

☐ Infusion supplies as per protocol
☐ Epinephrine 0.3mg IM x 1 prn (for first dose administration) May repeat in 15 minutes and call 911
☐ Diphenhydramine 50mg IV push over 2 minutes x1 prn (for first dose administration) for uticaria, pruritis or SOB

Flush Protocol

PICC or Midline:
☐ NSS 10ml IV as per “SASH” protocol
☐ Heparin 10 units pe ml 5mls IV as per “SASH” protocol

Port:
☐ NSS 10ml IV as per “SASH” protocol
☐ Heparin 100 units per ml 5mls IV as per “SASH” protocol

By signing this form and using our services, you are authorizing InfuCare Rx to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

Prescriber Signature:______________________________ **Date:** ______________

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