InfuCare Rx

Maternal-Fetal Medicine 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: ____________

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:

DIAGNOSIS

☐ D69.3 Immune Thrombocytopenic Purpura (ITP)
☐ E83.110 Neonatal Hemochromatosis
☐ O36.0110 Rh Sensitization or Severe Isoimmunization
☐ P61.0 Transient Neonatal Thrombocytopenia (NAIT)
☐ Other: ____________

FOR NAIT

Has HPA-1a testing been completed? ☐ Yes ☐ No
Results Confirm NAIT: ☐ Yes ☐ No

FOR ITP

Platelet Count: ____________ Date: ____________

MEDICAL HISTORY

Has patient previously received IVIG? ☐ Yes ☐ No
Patient Weight: ________ ☐ kg ☐ lbs Height: ________ ☐ cm ☐ in
Allergies: ____________
Line Access: ☐ Peripheral ☐ PICC ☐ Port
Delivery Method: ☐ Infusion Pump ☐ Other: ____________
Therapy Start Date: ____________ Therapy End Date: ____________
Nursing Coordination:

☐ Pharmacy to coordinate home health nursing visit as necessary: ☐ Yes ☐ No

☐ Home health nursing coordination not necessary. Reason:
- ☐ MD office to administer to patient
- ☐ Home health nursing already coordinated

Lab Orders: ____________
Concurrent Medications: ____________
Current Gestational Age: ____________
EDC: ____________
Gravida: ____________
Para: ____________

☐ Renal insufficiency
☐ Thromboembolic event
☐ CHF
☐ Diabetes
☐ HTN
☐ Other: ____________

PRESCRIPTION INFORMATION

Loading Dose: IVIG _____ gm or _____ gm per kg once daily for _____ day(s)
Maintenance: IVIG _____ gm or _____ gm per kg once daily for _____ day(s)
☐ Repeat course every ________ week(s) x ________ course(s)
☐ Refill x ________ (length of time)

☐ OK to round to the nearest vial size
☐ +/- 4 days to allow scheduling flexibility

Multiple doses will be administered on consecutive days unless ordered otherwise.
☐ non-consecutive days only

PREMEDICATION ORDERS/OTHER MEDICATIONS

Flush Protocol
☐ NaCl 0.9% 5ml
☐ NaCl 0.9% 10ml
☐ Heparin 10 units per ml
☐ Heparin 100 units per ml
☐ 250ml 0.9% NaCl for hydration
☐ Other: ____________

Pre-Medications & Other Medications
☐ Infusion supplies as per protocol
☐ Anaphylaxis Kit orders as per protocol
☐ Acetaminophen ________ mg PO prior to infusion
☐ Diphenhydramine ________ mg PO

Prescriber Signature: ____________ **Date:** ____________

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