InfuCare Rx

Anti-Infective Referral Form

of Pages Faxed: _____
Fax Referral To: 877-278-1544
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/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/ml 5mls IV as per "SASH" protocol

Port:
☐ NSS 10ml IV as per "SASH" protocol
☐ Heparin 100 units/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:** _____