IV Infusion Referral Form

University Hospitals Home Care Services

4510 Richmond Road
Warrensville Heights, OH 44128
Phone: 800-552-8442
Fax: 216-201-5127

Please complete each section of the referral form below and fax along with a copy (front and back) of all of the patient's pharmacy and medical insurance cards, the patient's demographic face sheet, and any relevant clinical notes/documents.

Provider Information

Prescriber: _____ **NPI:** _____

Phone: _____ **Fax:** _____ **Office Contact:** _____

Address: _____

_____

Patient Information

Name: _____ **DOB:** _____ ☐ M ☐ F

Address: _____

Phone: _____ **2nd Phone:** _____ **MRN:** _____

Primary Language: _____ **Functional Limitations:** _____

Clinical Information

Diagnosis (Include ICD-10 Code): _____

Weight:_____ ☐ lb ☐ kg **Height:**_____ ☐ in **IV access:** ☐ PIV ☐ PICC ☐ Port ☐ Other: _____

Patient's first dose? ☐ Yes ☐ No (If no, date of last dose: _____ Prior dose (in mg): _____)

Allergies: _____ **Latex allergy?** ☐ Yes ☐ No

Prior treatments & reason for discontinuation: _____

_____

History of kidney disease: ☐ Yes ☐ No If yes, SCr: _____ GFR/CrCl: _____ **History of heart failure:** ☐ Yes ☐ No

Referring provider's preferred site of care: ☐ Home Care Infusion Center ☐ Home Infusion ☐ Home Care to determine site of care
Site of care preference is subject to payer limitations, clinical appropriateness, and the availability of servicing providers.

Additional Notes: _____

Prescription Information

Medication: _____ **Dose:** _____ **Frequency**:_____
Based on the clinical judgement of the pharmacist, doses may be rounded up or down by no more than 10% unless checked here: ☐

Quantity (# of doses/infusions): _____

Preparation and Administration (please select one):
☐ Home Care to determine diluent (when required) and rate of administration per the product package insert.
☐ Specific diluent/rate required: Diluent: _____ Rate of Administration: _____

Nursing and Supplies: Home Care to provide supply items and nursing care to prepare and administer product as per package instructions.

Premedication(s):_____

PRN medication orders:_____

Lab orders: List any outpatient laboratory work related to this therapy you would like Home Care to draw in conjunction with the patient's medication administration, including the frequency for each lab order. Lab orders are good for the life of the prescription order (one year) unless otherwise indicated. (Lab orders are subject to availability.)

_____

Prescriber Signature

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize Home Care and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide infusion-related nursing services and supplies in conjunction with the therapy prescribed above.

Signature: _____ **Date:** _____