

ANTI-INFECTIVE INFUSION THERAPY REFERRAL FORM

Phone (844) 703.3645 Fax (855) 370.0086
10 Medical Parkway, Suite 107 Farmers Branch, TX 75234



Patient Information			PLEASE FAX INSURANCE CARD (FRONT AND BACK)			Prescriber Information			
Last Name		First Name		DOB		Practice/Facility Name			
Address						Address			
City		State		ZIP		City		State	ZIP
Phone			SSN			Prescriber Name			
Allergies						Latex Allergy Yes No			
Sex	Male	Female	Weight (kg)		Height (ft,in)		Prescriber NPI		
Insurance Plan			Plan ID #			Nurse/Key Contact		Phone/Pager	
						Fax		Email	

Diagnosis	
Primary ICD-10: _____	Height: _____
Secondary ICD-10: _____	Weight: _____
Allergies: _____	
Access: None or Type _____	

Therapy Ordered:	Anti-Infective Therapy 1	Anti-Infective Therapy 2
	Vancomycin Dose: _____ Ceftriaxone Frequency: _____ Cefepime Start Date: _____ Daptomycin Duration: _____ Other: _____	Vancomycin Dose: _____ Ceftriaxone Frequency: _____ Cefepime Start Date: _____ Daptomycin Duration: _____ Other: _____

Labs
BMP, CBC w/ differential q Monday. Trough level after 3rd dose and with routine Monday labs if Vancomycin or Aminoglycoside. Other: _____

Flushing
NS 5 ml SASH and prn Heparin 10 units Patient has signed a DNR: Yes No Heparin 100 units SASH and prn

Following Physician: _____	Date: _____
Anticipated time of Discharge Home: _____	Time: _____ Date: _____

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitution:

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date)

DISPENSE AS WRITTEN/Do Not Substitute (date)

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