ANTI-INFECTIVE INFUSION THERAPY REFERRAL FORM

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

Amber PHARMACY

Patient Information

PLEASE FAX INSURANCE CARD (FRONT AND BACK)

Last Name	First Name	DOB
Address		
City	State	ZIP
Phone	SSN	
Allergies	Latex Allergy ☐ Yes ☐ No	
Sex ☐ Male ☐ Female	Weight (kg)	Height (ft,in)
Insurance Plan	Plan ID #	

Prescriber Information

Practice/Facility Name		
Address		
City	State	ZIP
Prescriber Name		
Prescriber NPI		
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:	Vancomycin	Dose:
Ceftriaxone	Frequency:	Ceftriaxone	Frequency:
Cefepime	Start Date:	Cefepime	Start Date:
Daptomycin	Duration:	Daptomycin	Duration:
Other:		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

Heparin 100 units SASH and prn

Patient has signed a DNR: Yes No

Follwing 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)