Palmetto INFUSION

MRN:_____

Phone: 1-800-809-1265 ext 105 Fax: 1-888-417-3658

DOB:_____

ANTIEMETIC PLAN OF TREATMENT

1. Patient Name:_____Height (inches):_____Weight (lbs):_____

2. Allergies: _____

3. Diagnosis: ☐ Hyperemesis Gravidarum 021.1

☐ Other ICD-10 Code/description: _____

4. Orders: Heparin and saline flushes as needed to maintain line (A4221). Related items and/or supplies needed to administer medication and complete prescribed therapy (A4222).

☐ Zofran_____mg ☐ Subcutaneous ☐ IV Frequency: _____

☐ Reglan_____mg ☐ Subcutaneous ☐ IV Frequency: _____

☐ Other: _____

☐ Dispense _____ dose/doses ☐ Refills _____

Special orders: _____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

5. Physician's Signature:_____/_____Date: _____

No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials:_____NPI: _____

6. Fax updated supporting clinical MD notes with each order renewal or change in orders

Infusion order forms and Adverse Drug Reaction Guidelines are available at www.palmettoinfusion.com

Revised 12/9/2021

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DOB:_____

Guidelines for Prescribing Antiemetic Therapy

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:** _____

___ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-6)*
(Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)

___ Include patient demographic information and insurance information. (Copy of insurance cards if available)

___ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy.**

___ Other as requested: _____

Palmetto Infusion Services will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.

Please fax all information to 1-888-417-3658 or call 1-800-809-1265 for assistance.

Revised 12/9/2021