Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:		MRN:	
☐ New referral	☐ Order change	☐ Order Renewal	
Patient preferred clinic:			

Albumin Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:				
Patient Name:		Address:				
Date of Birth:		City, State, Zip:				
Height in inches:	Weight: LB or KG	Gender:	Allergies:	☐	See list ☐	NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐ _____ - Other:_____

REQUESTED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	
6	

IF NO: PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF YES:

LAST INFUSION DATE:

NEXT INFUSION DATE:

IF ORDER CHANGE:

☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

NOTE: We may require a detailed Letter of Medical Necessity or clinical supporting documentation (depending on diagnosis), to be able to verify eligibility and payment for this treatment through Medicare and/or other insurance plans.

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

IV

Diphenhydramine	◯ 25mg	◯ 50mg		
Methylprednisolone	◯ 40mg	◯ 125mg	◯ Other:	
Famotidine	◯ 20mg	◯ 40 mg		
Other:	◯			

PO

Acetaminophen	◯ 325mg	◯ 500mg	◯ 650mg	◯ 1000mg
Famotidine	◯ 20mg	◯ 40mg		
Diphenhydramine	◯ 25mg	◯ 50mg		
Fexofenadine	◯ 60mg	◯ 180mg		
Cetirizine	◯ 10mg			
Loratadine	◯ 10mg			
Other:	◯			

MEDICATION/DOSE:

☑ Albumin 25%

DOSE:

☑ Give _____gm to infuse over _____ minutes diluted in NS per protocol (max rate of 2ml/min)

FREQUENCY:

◯ One time dose

◯ Other: _____

SPECIAL/LAB ORDERS:

◯ _____

_____

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE:
Dispense as written/Brand medically necessary	Substitution permitted	