

Referral Status:		MRN:	
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change	<input type="checkbox"/> Order Renewal	
Patient preferred clinic:			

## Hydration 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: <input type="checkbox"/> See list <input type="checkbox"/> NDKA

### DIAGNOSIS: (PLEASE COMPLETE 2<sup>ND</sup> AND 3<sup>RD</sup> DIGITS TO COMPLETE ICD 10 FOR BILLING)

<input type="text"/>	- Other:
<input type="text"/>	- Other:

REQUESTED DOCUMENTATION:	PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?
1 Insurance information	IF NO: IF YES:
2 Most recent History & Physical	PLEASE STATE LAST INFUSION DATE:
3 Full medication list	REQUIRED WASHOUT FROM PREVIOUS THERAPY: NEXT INFUSION DATE:
4 Tried and failed therapies	<b>IF ORDER CHANGE:</b>
5	<input type="checkbox"/> Continue current order until insurance approved
6	

### 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.**

### MEDICATION/DOSE:

<input type="checkbox"/>	0.9% Sodium Chloride IV - _____ ml
<input type="checkbox"/>	0.45% Sodium Chloride IV - _____ ml
<input type="checkbox"/>	Dextrose 5% in 0.9% Sodium Chloride IV - _____ ml
<input type="checkbox"/>	Dextrose 5% in Lactated Ringers IV - _____ ml
<input type="checkbox"/>	Other: _____ - _____ ml
<input type="checkbox"/>	Additives: _____

### INFUSION RATE: (Will be given at a rate of 500ml/hour unless otherwise indicated below)

Alternative infusion rate: \_\_\_\_\_

### FREQUENCY:

One time dose  Other: \_\_\_\_\_

### DURATION:

\_\_\_\_\_ Weeks  \_\_\_\_\_ Months

### SPECIAL/LAB ORDERS:

\_\_\_\_\_

Refills sufficient for duration unless otherwise noted 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

<input type="text"/>	<input type="text"/>	<input type="text"/>
Dispense as written/Brand medically necessary	Substitution permitted	



# Palmetto

## INFUSION

Checklist for referrals to Palmetto Infusion:

Fax referral to 1.866.872.8920

- Patient demographics – address, phone number, SS#, etc.**
- Insurance Information – copy of the card(s) if possible**
- Plan of Treatment/Orders**
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- Any lab results or other diagnostic procedures to support the diagnosis**

Palmetto Infusion 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. Palmetto Infusion Call Center 800.809.1265. Thank you for the referral.

[www.PalmettoInfusion.com](http://www.PalmettoInfusion.com)