Referral Status:			MRN:
☐ New referral	☐ Order change		☐ 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: ☐ See list ☐ NKDA

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

	________ - Other:
	________ - Other:

REQUESTED DOCUMENTATION:

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

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO:	IF YES:
PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	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.

MEDICATION/DOSE:

☐ 0.9% Sodium Chloride IV - _______ml

☐ 0.45% Sodium Chloride IV - _______ml

☐ Dextrose 5% in 0.9% Sodium Chloride IV - _______ml

☐ Dextrose 5% in Lactated Ringers IV - _______ml

☐ Other:______________________________ - _____ml

☐ 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:

NURSING ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated.

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	

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 patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.PalmettoInfusion.com