

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

## Line Care 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"/> NKDA

### 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 INJECTION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INJECTION DATE:
4	Tried and failed therapies	FROM PREVIOUS	<b>IF ORDER CHANGE:</b>
5		THERAPY:	
6			
			<b>Continue current order until insurance approved</b>

### MEDICATION ORDERS:

#### CATHETER TYPE:

External catheter (PICC, Hickman, Broviac, Groshong, Midline)
  Implanted IV port
  Peripheral IV site  
 Multi-lumen catheter with \_\_\_\_\_ Lumens

#### MEDICATION:

Sodium Chloride 0.9% IV flush 5 - 10ml per line type as required.  
 Heparin 100 units/ml IV flush 1 - 5ml per line type as required  
 Heparin 10 units/ml IV flush 1 - 5ml per line type as required **(for pediatric patients)**

#### FREQUENCY:


Access, flush, and de-access per protocol every week  
 Access, flush, and de-access per protocol every 2 weeks  
 Access, flush, and de-access per protocol every 4 weeks  
 Other: \_\_\_\_\_

#### SPECIAL ORDERS:

\_\_\_\_\_

Refills x 12 months unless noted otherwise here:

### NURSING ORDERS: ADVERSE REACTION & ANAPHYLAXIS ORDERS:

<input checked="" type="checkbox"/> Start PIV/Access CVC <input checked="" type="checkbox"/> Flush device per facility standard flushing procedure <input checked="" type="checkbox"/> Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated	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"/>
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](http://www.PalmettoInfusion.com)