

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

Anti-infective/Antibiotic 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
	NDKA

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

- Other:
- Other:

REQUESTED DOCUMENTATION:	PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?
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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	IF ORDER CHANGE: <input type="checkbox"/> Continue current order until insurance approved
5	THERAPY:	
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:
 _____ to infuse via IV over _____ minutes in _____ ml
 Diluted in 0.9% Sodium Chloride Dextrose 5% in water Other: _____

FREQUENCY:

DURATION:
 _____ Weeks _____ Months Other: _____

SPECIAL ORDERS/LABS:

Refills: _____

LINE USE/CARE ORDERS:	ADVERSE REACTION & ANAPHYLAXIS ORDERS:
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- 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

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
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Dispense as written/Brand medically necessary	Substitution permitted

CHANGES MADE:

Please date and describe any changes below

Date:	Description:
9/4/2024	Updated Route, added nursing order-DR