Palmetto INFUSION®

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

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

Generic/Blank Plan of Treatment

Rev. 4.28.25

PATIENT DEMOGRAPHICS:

Patient Name:

Patient's Phone:	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 INJECTION DATE:
	NEXT INJECTION 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:

☐ _______ to infuse over _______ minutes in _____ml of ☐ 0.9% Sodium Chloride ☐ Dextrose 5% in water

☐ _______ to be given ☐ Subcutaneously ☐ Intramuscular ☐ IV push

☐ **Perform a post infusion monitoring period of ______ minutes**

FREQUENCY:

☑ ____

DURATION:

☐ ______ Weeks ☐ _____ Months ☐ Other:________________________

SPECIAL ORDERS:

☐ ____

☑ Refills:

NURSING ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

☑ Provide nursing care orders per Palmetto Infusion Nursing Procedures and post 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.

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	