

STAT REFERRAL

GENERAL IV ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ DOB: _____

HT: _____ in WT: _____ lbs kg Sex: Male Female Allergies: NKDA, _____

Physician Name _____ Contact Name _____ Contact Phone # _____

NPI #: _____ Tax ID#: _____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD 10 CODE + DESCRIPTION) _____

Secondary Diagnosis: (ICD 10 CODE + DESCRIPTION) _____

Does patient have venous access? YES NO If yes, what type MEDIPORT PIV PICC LINE OTHER: _____

PRESCRIPTION ORDERS

- a) ALL MEDIPOINTS / IV ACCESSES WILL BE FLUSHED WITH HEPARIN OR SALINE PER HOSPITAL POLICY PRN
- b) 500 mL BAG OF 0.9% NS MAY BE HUNG AT KVO RATE

PLEASE SELECT FROM BELOW:

- Perform port flush every _____ weeks per hospital policy.
- Perform IV site care per hospital policy.

NOTE: For patients with central venous access, please select: D/C AFTER LAST DOSE

DRUG 1	DOSE	ROUTE	FREQUENCY	DURATION
DRUG 2	DOSE	ROUTE	FREQUENCY	DURATION
DRUG 3	DOSE	ROUTE	FREQUENCY	DURATION
DRUG 4	DOSE	ROUTE	FREQUENCY	DURATION

LABS			NOTES/INSTRUCTIONS/OTHER
SELECT	LAB REQUESTED	FREQUENCY	
<input type="checkbox"/>	NONE	NA	
<input type="checkbox"/>	CBC w/ Diff		
<input type="checkbox"/>	BMP		
<input type="checkbox"/>	CMP		
<input type="checkbox"/>	BUN/CREATININE		
<input type="checkbox"/>	ESR		
<input type="checkbox"/>	CRP		
<input type="checkbox"/>	CPK		
<input type="checkbox"/>	Other:		
<input type="checkbox"/>	Other:		

Physician's Signature _____ Time _____ Date _____
 *Signature Must Be Clear and Legible

Cosignature (If Required) _____ Time _____ Date _____
 *Signature Must Be Clear and Legible

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.