



134 Prince Ave Suite B
 Bellingham, WA 98226
 Phone (360) 933-4892
 Fax (360) 933-1197

Infusion Therapy Referral Form

Please fax the following information to **(360) 933-1197** to facilitate a swift and easy referral:

DEMOGRAPHICS

Patient Name: _____ Date of Birth: _____ Gender: F M

Home Phone: _____ Cell: _____ Work: _____

Address: _____

City: _____ State: _____ Zip: _____

Legally Responsible Representative: _____ Relationship to Patient: _____

FINANCIAL INFORMATION

**Please fax a copy of front and back of all insurance cards if available.

Payor: _____ ID#: _____ Group#: _____

Cardholder: _____ Self Spouse Child

ORDERS (check boxes to initiate therapy)

Height: _____ Weight: _____ Allergies: _____

Diagnoses: _____ ICD-9: _____
 _____ ICD-9: _____

Medication Orders:

Medication/Dose: _____ Route: IV SQ Other: _____

Instructions: _____ Duration of therapy: _____ TBD (≤ 1 yr)

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Clinical pharmacist to monitor drug levels and adjust dose accordingly

- ◆ Alteplase 2mg IV to de clot central IV access per Infusion Solutions protocol as needed for occlusion.
- ◆ Flush line with D5W, 0.9% NaCl and/or Heparin 10 units/ml or 100 units/ml per Infusion Solutions protocol.
- ◆ Infusion Reaction Management per Infusion Solutions protocol as needed.

Nursing Orders:

- ◆ If no central IV access, RN to insert peripheral IV, rotate site every 72 to 120 hours or as needed.

Other: _____

Lab Orders:

_____ One time weekly every _____

_____ One time weekly every _____

 Prescriber Signature

 Date

 Please Print Name