Infusion Therapy Services – Phone 812-254-2498

INFUSION REFERRAL FORM

Patient Information:

Name: ____
Last First M.I.
D.O.B. _____________
Diagnosis related to treatment: ____________________________
Secondary diagnoses: ______________________
Height: _______________ Weight: ______________ Diabetic: Y / N
Primary Care Physician: ____

Infusion Access:

- ❑ Peripheral IV (location____________)
- ❑ PICC _____ Midline ______ Central Line _____ (# of Lumens_________)
- ❑ Implanted Port (length of needle___________)
- ❑ Hickman
- ❑ SQ

Home Health and Physician Information:
Most IV Services require Home Health Care

- ❑ Home Health Care Agency Name_____________________________
- ❑ WB to assign a Home Health Care Agency

Please include the following forms with this referral form:

- ✓ Physician's Order
- ✓ Face Sheet (for insurance information and patient demographics)
- ✓ H &P (for supporting documentation, current medications, and allergies)
- ✓ Insurance Card Copies (if available)

Referral Contact Person: ___________________________________

Order: ____

Physician Signature: _____________________________ Date: __________
Physician Name: _____________________________ NPI: _____________

Anticipated Discharge Date: __________________

First Dose Date and Time: __________________

PLEASE FAX TO: 844-254-9242