



Return Signed RX via Fax to 256.837.2465

IV Antibiotic Referral Form

To:	From:
Intake Number: 800.838.2464	Phone Number:
Date:	Number of Pages, Including Cover:
Patient Name:	DOB:
Diagnosis/ICD-10:	Allergies:

Initiation/Continuation of infusion therapy orders (drug, dose, rate, duration and frequency):

1. _____
2. _____
3. _____
4. _____

IV Access Device (check one): Peripheral Central Flush IV access device with heparin/saline per KabaFusion protocol

Supplies/Pump/Pole as appropriate to administer ordered therapy: _____

Anaphylaxis Kit – EpiPen Auto-injector use as directed. 2 Pak Kit PRN, refill x 1 year

Laboratory Orders: _____

Additional Comments/Orders: _____

Prescriber Signature: _____ Date: _____

Print Prescriber Name: _____ NPI#: _____

Please fax the following information:

- Patient Demographics – include insurance information. **We will obtain authorization** unless the insurance dictates otherwise
- H & P **OR** progress note(s) describing diagnosis and clinical status
- Recent Laboratory Results

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