**Return Signed RX via Fax to: 501.223.9508**

# IV Antibiotic Referral Form

| To: | From: |
|---|---|
| Intake Number: 501.227.0900 | 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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