



Return Signed RX via Fax to: 317.870.2085

## IV Antibiotic Referral Form

|                             |                                   |
|-----------------------------|-----------------------------------|
| To:                         | From:                             |
| Intake Number: 317.870.2090 | Phone Number:                     |
| Date:                       | Number of Pages, Including Cover: |
| <b>Patient Name:</b>        | <b>DOB:</b>                       |
| <b>Diagnosis/ICD-10:</b>    | <b>Allergies:</b>                 |

**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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