Return Signed RX via Fax to: 757.424.5871

IV Antibiotic Referral Form

To:	From:
Intake Number: 757.424.4822	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: ______________________________

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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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