KabaFusion
Patient-Focused Infusion Therapy

Return Signed RX via Fax to: 502.515.3509

IV Antibiotic Referral Form

To:	From:
Intake Number: 502.515.3500	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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