



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):

- _____
- _____
- _____
- _____

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

CONFIDENTIALITY NOTICE

The following includes confidential, proprietary information that is the sole exclusive property of KabaFusion. No rights in, relating to, or derived from such information are assigned or otherwise transferred by this document, and the recipient of such information is subject to obligations of secrecy to and for the benefit of KabaFusion. Any unauthorized use or disclosure of such information is strictly prohibited. This message, together with any attachments, is intended only for the use of the individual or entity to which it is addressed and may contain information that is confidential and prohibited from disclosure. If you are not the intended recipient, you are hereby notified that any dissemination, or copying of this message, or any attachment, is strictly prohibited. If you have received this message in error, please notify the original sender immediately by telephone or by return fax and shred this document along with any other documents. Thank you.

KabaFusion Infusion Pharmacy | 5694 Shepherdsville Road | Louisville, KY 40228
Phone: 502.515.3500 | Fax: 502.515.3509 | www.kabafusion.com