



Authorization obtained by KabaFusion
KabaFusion Staff Initials: _____
Date: _____

Ambulatory Infusion Center
Patient Referral and Prescription for Infusion Therapy
Return Signed RX via Fax to 1-888-310-0856

To: Tina Benkendorfer, Pharm.D.		From:	
Fax Number: 1-888-310-0856		Phone Number:	
Preferred Start Date:		Number of Pages Faxed, Including Cover:	
Patient Name:		DOB:	
Diagnosis/ICD-10:	Height:	Weight:	Allergies:

Initiation/Continuation of infusion therapy orders (drug, dose, rate, frequency and duration):

ANTIBIOTICS					
Ceftriaxone:	Levofloxacin:	Ertapenem:	Vancomycin:	Daptomycin:	Dalbavancin:
<input type="checkbox"/> 1 gm IV q24h	<input type="checkbox"/> 500mg IV q24h	<input type="checkbox"/> 1 gm IV q24h	<input type="checkbox"/> Per pharmacy protocol	<input type="checkbox"/> _____ mg IV q24h	<input type="checkbox"/> 1 gm X 1 Dose
<input type="checkbox"/> 2 gm IV q24h	<input type="checkbox"/> 500mg IV q48h	<input type="checkbox"/> 0.5 gm IV q24h	<input type="checkbox"/> _____	<input type="checkbox"/> _____ mg IV q48h	<input type="checkbox"/> 500 mg X 1 Dose to be given 1 week after 1 gm dose
	<input type="checkbox"/> 750mg IV q24h		IV q _____		
	<input type="checkbox"/> 750mg IV q48h				
Duration: _____	Duration: _____	Duration: _____	Duration: _____	Duration: _____	Duration: _____

ADDITIONAL IVs

Sodium Ferric Gluconate Complex (Ferrelecit®) 125mg IV q _____; Duration: _____

IV Fluid: 0.9% NaCl IV at _____ ml/hr OR _____

ADDITIONAL MEDICATION ORDERS

Acetaminophen 650 mg PO q4h prn pain/fever OR Acetaminophen 650 mg PO _____

Diphenhydramine 25 mg IV/PO q6h prn itching OR Diphenhydramine _____

Ondansetron 4 mg IV q6h prn nausea/vomiting

IV Access Device: Establish/manage IV access and flush IV access device per policy
(Use normal saline solution for peripheral access, and heparin 100 units/ml solution for central access.)

Patient may be discharged home with Peripheral IV access until infusion therapy completed.

Laboratory Orders:

Dietary Orders: Patient may have general diet during visit OR _____

Additional Comments/Orders:

Prescriber's Signature: _____ Date: _____ Time: _____

Print Prescriber's 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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