MedRX Infusion
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Date Medication Needed

Ship to: ☐ Patient ☐ Prescriber ☐ Other: _____

Infusion Therapy

This referral form is provided in order to best serve our patients and prescribers. Patients may choose any pharmacy of their choice.

Complete patient demographics below or otherwise provide the information requested along with this referral form. Also needed: 1) Patient insurance information (front and back of card) 2) History and physical, chart notes, laboratory results and other diagnostic tests needed to support the use of this medication 3) patient's medication history related to their current diagnosis/problem.

Patient name: _____ Date of birth: _____ height: _____ weight: _____

Address: _____ Allergies/Intolerances: _____

Phone number(s): _____ ☐ No known allergies: _____

Treatment Diagnosis/Problem(s): _____

Prescriber name: _____ Contact person: _____

Office Address: _____

Phone number: _____ Fax number: _____ NPI number: _____

Prescription Information

Provide medication name, dose, route of administration, frequency, duration:

Therapy is going to be administered ☐ physicians office ☐ infusion suite ☐ in patients home

☐ Home Health care nursing is needed

☐ Patient has never received this medication before. Please provide anaphylaxis kit (epinephrine, diphenhydramine) per MedRx and nursing policy and procedure.

☐ Patient has an existing intravenous access device (catheter type) _____ date placed _____ and will require Home Health to maintain the intravenous catheter and MedRx to provide supplies needed including NaCl 0.9% flush and Heparin 100units/ml flush per nursing and pharmacy protocol

Physicians Signature:_____ Date: _____