



IV Infusion Referral

Please fax referral form with patient face sheet, insurance information, and recent office visit notes along with recent lab work to (509) 787-4865.

Referring Provider: _____ Phone Number: _____ Fax Number: _____ Patient's Primary Care Provider: _____ Phone Number: _____ Prescribing Provider Signature: _____ Date: _____
Patient Name: _____ DOB: _____ Phone Number: _____ Allergies: _____ Pt. Weight: _____ Pt. Height: _____
Diagnosis Code: <input type="text"/> Medication: <input type="text"/> Dose: <input type="text"/> Route: <input type="text"/> Infusion Rate: <input type="text"/> Frequency: <input type="text"/> Duration of Treatment: <input type="text"/> Number of Tx already Administered: <input type="text"/> Lab Orders: <input type="text"/> Lab Order Frequency: <input type="text"/>



Vascular Access Device

<input type="checkbox"/> Peripheral IV	<input type="checkbox"/> Midline	<input type="checkbox"/> PICC	<input type="checkbox"/> Central
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Insertion Date: Location:

Lumens: Port Type:

Catheter Length: Exposed Catheter Length (CM):

Arm Circumference CM:

Implanted Access Port

<input type="checkbox"/> Power	<input type="checkbox"/> Non-Power
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Insertion Date:	Location:
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Huber Needle Gauge/Size:

<input type="checkbox"/> 20 Gauge/ 3/4 Inch	<input type="checkbox"/> 20 Gauge/1 Inch
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<input type="checkbox"/> When Accessed Flush and lock with 10 mL 0.9% NS once daily and after each medication administrations
<input type="checkbox"/> Maintenance every 3 months Flush with 10 mL of 0.9% NS and Heparin Locked 3 to 5mL Heparin (100units/mL)