



Premier Point Ambulatory Infusion Center
Phone: 312.763.2200 Fax: 312.763.2345 eFax: 312.275.8122
Infusion Referral Form

Patient Name: _____ SSN#: _____ Phone#: _____
 Address: _____ APT#: _____ City: _____ State: _____ Zip Code: _____
 DOB: _____ HT: _____ WT: _____ Emergency Contact: _____ Phone #: _____
 Email Address: _____ Allergies: _____ Diagnosis: _____
 Primary Insurance Carrier: _____ Primary Insurance Phone#: _____
 Card Holder ID: _____ Group#: _____ (Please Attach Copy of Card)

Line Type: Peripheral Port SL PICC DL PICC CVL (Please attach placement paperwork)

Prescriber: _____ Office: _____ Contact: _____
 Office Address: _____ City: _____ State: _____ Zip Code: _____
 Phone: _____ Fax: _____ NPI#: _____ DEA#: _____
 Prescriber Signature: _____ Date: _____ Start of Care Date: _____
 (Please note for Insurance compliance the prescribing physician must sign Rx, no stamps or nurse signatures)

| MEDICATION/s | DOSAGE | ROUTE | FREQUENCY |
|--------------|--------|-------|-----------|
| | | | |
| | | | |
| | | | |

Saline flush per Pharmacy protocol Heparin flush (10 U/ml, if pedia; 100 U/ml, if adult): 5 ml at end of SASH Other: Cathflo PRN

Pre-Medications: (medications in this section are a single dose prior to IV administration or other meds, unless otherwise indicated)

- | | |
|--|---|
| <input type="checkbox"/> Acetaminophen 650 mg P.O | <input type="checkbox"/> Hydrocortisone (Solu-cortef) _____ mg IV |
| <input type="checkbox"/> Acetaminophen 1000 mg P.O | <input type="checkbox"/> Methylprednisolone (Solu-Medrol) _____ mg IV |
| <input type="checkbox"/> Diphenhydramine 25 mg <input type="checkbox"/> PO <input type="checkbox"/> IV | <input type="checkbox"/> Cetirizine HCl (Quzyttir) _____ mg IV |
| <input type="checkbox"/> Diphenhydramine 50 mg <input type="checkbox"/> PO <input type="checkbox"/> IV | Other: _____ |

PRN Medications:

- Diphenhydramine HCl _____ mg IV x 1 PRN for infusion hypersensitivity reactions.
- Solu-Medrol _____ mg IV x 1 PRN for hypersensitivity reactions.
- Zofran _____ mg IV x 1 prn nausea
- Topical Anesthetic cream apply to skin prior to PIV catheter insertion as needed for pain

Anaphylaxis and ADR Prevention Kit Orders:

- Per Pharmacy protocol (Epinephrine, Diphenhydramine oral/injectable, acetaminophen, NS bag)
- Oxygen inhalation at _____ liters/min via NC/Face mask

Additional Orders: For CVD, PICC

- Catheter Care only: Flush access device _____ (frequency) with NS + Heparin to maintain patency.

*****Please attach History/Physical, Most Recent Labs, and Current Medication List*****

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