Total Infusion Care

3041 West Horizon Ridge Parkway Suite 100

Henderson, NV 89052

Phone: (702) 778-8880 Fax: (702) 778-8882

MEDICAL REFERRAL FORM

Patient Name:______________________________D.O.B.______________Gender: M F HT:________in WT: ________LB

Address:______________________________City:______________State:__________Zip Code:__________

Phone ( )______________ ALLERGIES:____________________DIAGNOSIS:______________________

PLEASE LIST ALL FAILED MEDICATIONS RELEVANT TO THE DIAGNOSIS:______________________________

PLEASE COMPLETE THE FOLLOWING AND FAX COPY OF PATIENT'S LAB REPORTS

Anti-biotics: ADULT DOSE(Circle and/or Check)

- ☐ CUBICIN (Daptomycin) (4 TO 6 mg/kg) _______mg IV Push Once Daily for (2 to 6 Weeks) ___________Weeks
- ☐ CEFEPIME (1 to 2gm) IV Push q24h, q12h or q8h for (1 to 8 Weeks) ___________Weeks
- ☐ CEFAZOLIN (1 to 2gm) IV Push q24h, q12h or q8h for (1 to 8 Weeks) ___________Weeks
- ☐ INVANZ (Ertapenem) 1gm IVPB Once Daily for (3 to 14 Days) ____________Days
- ☐ MERREM (Meropenem) (500mg to 1gm) IVPB q24h, q12h, q8h for (1 to 8 Weeks) ____________Weeks
- ☐ ROCEPHIN (Ceftriaxone) (1 to 2 gm)_______gm IV Push Once Daily (MAX=4 gm /Day) for (1 , 2 , 3, to 8 weeks) ____________Weeks
- ☐ VANCOMYCIN 1 gm IVPB q12h or q24h for (2 TO 6 Weeks) ___________Weeks. Dose per Pharmacy: Need Base Line Labs Drawn; CBC, and CMP
- ☐ ***OTHER:***__________________***SIG:***______________________***DURATION:***__________________***REFILLS:***________

DRUG: DIRECTIONS: DURATION:

Other Medications)

- ☐ INJECTAFER (750 mg weekly x 2 infusions)
- ☐ REMICADE (infliximab) (5mg/kg week 0, 2, 6 & every 8 weeks after) (duration _______________)
- ☐ ENTYVIO (Vedolizumab) (300mg week 0, 2, 6 & every 8 weeks after) (duration ___________________)
- ☐ ***OTHER :***__________________***SIG:***______________________***DURATION:***__________________***REFILLS:***________

DRUG: DIRECTIONS: DURATION: REFILLS:

Total Parenteral Nutrition

- ☐ IV Over ____ HRS
- ☐ VIA_____(access)
- ☐ Daily x (months)

Enteral

- ☐ Brand: ___________

____ML Over ___HRS

IVIG:

☐ IVIG Name: __________

Dose_________Grams

Frequency____________

Length of Therapy________

# of Refills ___________

Anti-Emetics:

- ☐ Promethazine 25 to 50 mg DEEP IM or IV MAX = 100 mg / DAY
- ☐ Zofran (Ondanstron) 4, 8, or 16 mg IVPB OVER 30 MIN ONCE, TWICE, OR THREE TIMES DAILY

Other : ***Sig:*** ***Duration:*** ***Refill:***

Doctor Name:____

Street Address:______________________City:____________State:__________Zip Code:______________

Telephone number: ( ) ______________ Fax: ( )______________________

DEA #______________State Lic # ______________NPI #:______________

Signature:______________________________Date:______________________