Patient: ______________________________

INFUSION THERAPY REFERRAL FORM

Patient Name:			Date of Birth:
Address:			
City:		State:	Zip Code:
Home Phone:		Alternate Phone:	
Allergies:			
Height:	Weight:	Type of Access:	

Labs:

- ❑ BPM, CBC w/ differential q Monday
- ❑ Trough level after 3rd douse and with routine labs if vancomycin or Aminoglycoside
- ❑ Other: ______________________________
- ❑ NS 5 ml SASH and prn
- ❑ Heparin 20 units
- ❑ Heparin 100 Units SASH and prn

Nursing:

- ❑ Plaza to coordinate nursing services
- ❑ Home Health Agency: ____________________
- ❑ MD's office will coordinate nursing
- ❑ Nursing will NOT be required

Delivery Instruction:

- ❑ Patient's Home
- ❑ Infusion Suite
- ❑ Physician's Office
- ❑ Other: ______________________________

Following Physician Name:	Phone:
Prescribing Physician Name:	Phone:
Signature:	Date:

Fax completed form to (626) 585-8031

900 S Arroyo Pkwy. Unit #150 Pasadena, CA 91105

Tel: (626) 585-8521 Fax: (626) 585-8031 1 800-RX Plaza

www.plazahomecarepharmacy.com