INFUSION THERAPY REFERRAL FORM

Phone (877)794.9833 Fax (855)370.0086
215 10th Street, Suite 110 Des Moines, IA 50309

Pharmacy HyVee SOLUTIONS

Patient Information

Last Name	First Name	DOB	Practice/Facility Name		
Address			Address		
City	State	ZIP	City	State	ZIP
Phone	SSN		Prescriber Name		
Allergies	Latex Allergy ☐ Yes ☐ No		Prescriber NPI		
Sex ☐ Male ☐ Female	Weight (kg)	Height (ft,in)	Nurse/Key Contact	Phone/Pager	
Insurance Plan	Plan ID #		Fax	Email	

Diagnosis

Primary ICD-10: _____ Height: _____
Secondary ICD-10: _____ Weight: _____
Allergies: _____
Access: None or Type _____

Therapy Ordered:	Anti-Infective Therapy 1		Anti-Infective Therapy 2	
	Vancomycin Ceftriaxone Cefepime Daptomycin Other:	Dose: _____ Frequency: _____ Start Date: _____ Duration: _____	Vancomycin Ceftriaxone Cefepime Daptomycin Other:	Dose: _____ Frequency: _____ Start Date: _____ Duration: _____

Labs

BMP, CBC w/ differential q Monday.
Trough level after 3rd dose and with routine Monday labs if Vancomycin or Aminoglycoside.
Other: _____

Flushing

NS 5 ml SASH and prn
Heparin 10 units
Heparin 100 units SASH and prn
Patient has signed a DNR: Yes No

Follwing Physician: _____ Date: _____

Anticipated time of Discharge Home: _____ Time: _____ Date: _____

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitution: _____

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitution:

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date)

DISPENSE AS WRITTEN/Do Not Substitute (date)

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