INFUSION ENROLLMENT FORM

RED RIVER Rx
INFUSION PHARMACY

REFERRAL SOURCE INFORMATION

REFERRAL SOURCE	CONTACT NAME	PHONE

Please fax this completed sheet along with the following documents for an **EASIER** and more **EFFICIENT** referral process.
Coverage criteria may vary by payer.

- ☐ **DEMOGRAPHIC SHEET -** Must include SS#, Phone#, Emergency Contact and Insurance Info
- ☐ **SIGNED PHYSICIAN ORDER -** Must be signed by MD/APN
- ☐ **HISTORY & PHYSICAL -** Must have diagnosis w/ICD 10 Code, height & weight, allergies, history of present illness, vascular access
- ☐ **MED LIST –** Need discharge med list or current home med list
- ☐ **CURRENT LABS -** including BMP, and if pertinent, peak/trough information

PATIENT INFORMATION

PATIENT NAME (First, Last, MI)

SEX ☐ **MALE** ☐ **FEMALE** **DOB** **SOCIAL SECURITY #**

PRIMARY PHONE # **PATIENT STATUS:** ☐ **New to Therapy** ☐ **Continuing Therapy**

CLINICAL INFORMATION

HEIGHT (INCHES)	WEIGHT ☐ lbs. ☐ kg	ALLERGIES

VASCULAR ACCESS: ☐ **Peripheral** ☐ **Midline** ☐ **PICC** ☐ **CVC** ☐ **PORT** **# LUMENS:** ☐ **Single** ☐ **Double** ☐ **Triple**

PRIMARY DIAGNOSIS	ICD-10

HAS THE PATIENT RECEIVED THIS MEDICATION BEFORE? ☐ **Yes** ☐ **No**

HOME THERAPY INFORMATION

DISCHARGE DATE:	DATE/TIME THE 1ST HOME DOSE IS DUE:

HOME HEALTH (if applicable - include contact & phone):

PRIMARY CARE PHYSICIAN:	PHYSICIAN FOLLOWING THERAPY (if not writing original order):

ORDER INFORMATION

ROUTE: ☐ **Intravenous (IV)** ☐ **Subcutaneous (SQ)** ☐ **Intramuscular (IM)**

MEDICATION	DOSE
FREQUENCY	**DURATION**

LAB ORDERS: ☐ **Weekly CMP** ☐ **Weekly CBC** ☐ **Vancomycin trough twice weekly** ☐ **Weekly CPK for Daptomycin**
☐ **Other:**

LINE MAINTENANCE: ☐ **Administer medication via SASH method** ☐ **Administer medication via SAS method**
☑ **Weekly dressing change to be performed by nurse** ☐ **Home Health nurse to pull PICC line after therapy completion**

Clinical Pharmacists are available to provide pharmacokinetic dosing as requested by the physician to ensure therapeutic blood levels.

*Red River professionals assess and monitor patients on a case-by-case basis, coordinating therapy with the patient's physician, home health agency and family members.

Red River Infusion Pharmacist to follow dosing for prescribed therapy, if applicable:

☐ **Yes** ☐ **No** *-If No, who is following?* ☐ **Physician** ☐ **Hospital Pharmacist**

Physician Signature **Date**

Please fax your Enrollment Form to: 833-439-0587

***By signing this enrollment form, you are agreeing to utilize our services and authorize Red River Infusion Pharmacy and its employees to act as your pre-authorization agent when communicating with medical and prescription insurance companies. The information contained in this facsimile message is privileged and confidential information intended for the use of the addressee listed above. If you are neither the intended recipient or the employee or agent responsible for delivering this information to the intended recipient, you are hereby notified that any disclosure, copying, distribution, or the taking of any action in reliance on the contents of this transmitted information is strictly prohibited. If you have received this transmitted information in error, please immediately notify us at (903) 792-2753 to arrange for the return of documents to us.**