Infusion Information

Referral Form

Please fax completed form to:

Fax: 386-385-7871
Phone 386-456-3000
AccordSpecialty@gmail.com

PATIENT INFORMATION				PRESCRIBER INFORMATION			
Name:				Prescriber Name:			
Address:				Address:			
City, State, Zip:				City, State, Zip:			
Phone:				NPI AND License:			
DOB:		Gender:		Px:		Fax:	

CLINICAL INFORMATION

Medication				
Vascular Access:	☐ Peripheral IV	☐ PICC	☐ Implant Port	☐ Other:

PRESCRIPTION INFORMATION

Pre-Medications	☐ Acetaminophen ____ mg 30 mins prior to infusion PO			
	☐ Diphenhydramine ____ mg 30 mins prior to infusion	☐ PO	☐ IV	
	☐ Solu-Medrol ____ mg slow IVP			
	☐ Solu-Cortef: ____ mg slow IVP			
	☐ Other:			
Hydration Orders	Infuse ____ mg of ____ solution	☐ Prior To	☐ Following	
Flushing Protocol	☐ **Sodium Chloride 0.9%** 5-10 mL pre and post medications			
	☐ **Heparin** ____ units/mL Sig:			
Adverse Reactions & Anaphylaxis	1. Stop Infusion. 2. Adminster medications per protocol. 3. If life threatening reactions, notify 9-1-1 and prescriber.			
	* Acetaminophen (Tylenol) 500 mg PO every 4 hours PRN myalgia or fever >101.3			
	* Diphenhydramine (Benadryl) 25 mg IV every 4-6 hours PRN urticaria, pruritus, or shortness of breath			
	* If symptoms are rapidly progressing or continue after the diphenhydramine, give epinephrine (1:1000 strength) 0.3 mL SC.			
	☐ **Diphenydramine 50 mg/mL**, IM/IV dose: Adult = 10-50 mg per dose every 4-6 hours as needed. Administer as IV push over 5 mins.			
	☐ **Epinephrine 1:1000 (1 mg/1 mL)**, SubQ Dose: Adult = 0.2-0.5 mL per dose every 15-30 mins for 3-4 doses or every 4 hours as needed.			
Pump/Supplies	☑ Pump and supplies as needed for administration and appopriate disposal of infusion medications.			
Skilled Nursing	☑ As needed for IV access, administration and appopriate clinical monitoring			

REQUIRED DOCUMENTATION

• Associated Referral for Medication as listed above

PRESCRIBER SIGNATURE

By signing below, I certify that the above therapy is medically necessary and that the provided medical information is accurate to the best of my knowledge. I authorize Accord Specialty to initiate and execute any insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed. I understand that I can revoke this designation by providing notice to Accord.

Prescriber's Signature: _____ Date: _____