Premier Point Ambulatory Infusion Center

Referral For Infusion Services

PATIENT NAME:_____

ADDRESS:_____

PHONE#:_____

DATE OF BIRTH:_____

HEIGHT:_____ WEIGHT:_____

DIAGNOSIS:_____

ALLERGIES:_____

INSURANCE: ☐NEXT CARE ☐MEDNET ☐BETTER CARE ☐QATAR INSURANCE CO

☐ALICO INSURANCE ☐SAUDI ARABIAN INSURANCE ☐LIVA

PRESCRIBER:_____ OFFICE:_____

OFFICE ADDRESS:_____

PHONE#:_____

PRESCRIBER SIGNATURE:_____DATE:_____

START OF CARE DATE:_____

PRESCRIBING PHYSICIAN MUST SIGN PRESCRIPTION. NO STAMP OR NURSE SIGNATURE

MEDICATION/s	DOSAGE	ROUTE	FREQUENCY

☐Saline flush per pharmacy protocol

☐Heparin flush (10 U/ml, if pedia; 100 U/ml, if adult): 5 ml at end of SASH

☐Other: Cathflo PRN

Pre-Medications:(medications in this section are a single dose prior to IV administration or other meds, unless otherwise indicated)

PRN Medications:

Anaphylaxis and ADR Prevention Kit Orders:

Additional Orders: For CVD, PICC

*****Please attach [] History/Physical, [] Most Recent Labs, and [] Current Medication List*****