WVU Medicine HOME INFUSION
Operated by WVUH Specialty Pharmacy & Home Infusion

Traditional Therapy
IV INFUSION
PATIENT REFERRAL FORM

Referral Fax: (304) 974-3341
Referral Email: homeinfusion@wvumedicine.org

If external referral (patient outside WVU Medicine), also attach a copy of patient demographics, insurance information, & pertinent clinical notes/labs.

PROVIDER:		CONTACT:	
OFFICE/ADDRESS:		PHONE:	FAX:

PATIENT INFORMATION

NAME:		DOB:	SEX: ☐M ☐F
MRN:	PHONE:	ALLERGIES:	
ADDRESS:			
PRIMARY DIAGNOSIS & CODE:		Face-to-Face Completed: ☐ Yes ☐No	HT: _____ ☐cm ☐in
Freedom of Choice discussed w/ Patient: ☐ Yes ☐ No		Office visit date: _____	WT used to calculate dose: _____ ☐kg ☐lb
EMERGENCY CONTACT:		PHONE:	

HOME INFUSION THERAPY

DRUG: _____ DOSE: _____ mg/kg = total dose _____mg FREQUENCY: _____

INFUSE OVER: _____ minutes - **or** - RATE: _____

END DATE: _____ - **or** - DURATION OF THERAPY: _____ (circle one) DOSES / WEEKS / MONTHS

FIRST DOSE ADMINISTERED? ☐ YES ☐ NO If yes - DATE/TIME OF LAST DOSE (if applicable): _____

LINE INSERTION DATE: _____

LINE TYPE: _____ # of Lumens: _____ Gauge: _____

LABS: ☐ N/A ☐ Follow OPAT GUIDELINES FOR LABS AND FREQUENCY
☐ Other Labs: _____
☐ Frequency: _____

LINE MAINTENANCE AND FLUSHING:
☐ Per WVU Medicine Home Infusion standing orders
☐ Other: _____

SPECIFIC ADMINISTRATION INSTRUCTIONS (if applicable):
_____

NURSING ORDERS

☐ Infusion nurse visits to administer medication, assess and educate patient.
☐ Line and site care per WVU Medicine Guidelines and nursing agency policy and procedure.
☐ Stop infusion if hypersensitivity or infusion-related reaction develops.
☐ Follow provider's EMERGENCY MEDICATION orders and nursing agency policy and procedure for anaphylactic /adverse reaction and notify provider.
☐ Educate patient on s/s of reaction and to seek medical attention including emergency care 911, if symptoms occur.
☐ Other (if applicable): _____

PRESCRIBING PHYSICIANS SIGNATURE	NPI	DATE
_____	_____	_____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize Allied Health Solutions and/or its affiliates to complete and submit prior authorization (PA) requests to payers for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.