Allied HEALTH SOLUTIONS
HOME INFUSION
An affiliate of WVUMedicine

Specialty Medication
IV/SUBQ INFUSION
PATIENT REFERRAL FORM

Referral Fax: (304) 974-3341
Referral Email: AHShomeinfusion@wvumedicine.org
Phone: (304) 974-3340
If external referral (patient outside WVU Medicine), also attach a copy of patient demographics, insurance information, & pertinent clinical notes/labs.

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

PATIENT INFORMATION

NAME:		DOB:	SEX: ☐M ☐F
MRN:	PHONE:	ALLERGIES:	
ADDRESS:			
PRIMARY DIAGNOSIS AND CODE:			HT: ☐cm ☐in WT: ☐kg ☐lb
EMERGENCY CONTACT:		PHONE:	

PRE-MEDICATIONS	PRN / EMERGENCY MEDICATIONS
☐N/A ☐acetaminophen 650 mg ORAL once 30-60 minutes prior to infusion ☐diphenhydramine 25 mg ORAL once 30-60 minutes prior to infusion ☐methylprednisolone 125 mg IV once 30 minutes prior to infusion ☐hydrocortisone 100 mg IV once 30 minutes prior to infusion ☐other: _____	☐epinephrine 0.5 mg IM once; may be repeated every 5-15 minutes, if needed, for 3 total doses ☐diphenhydramine 25-50 mg IV once if needed ☐hydrocortisone 100 mg IV once if needed ☐acetaminophen 325-650 mg ORAL once if needed ☐other / per provider protocol (specify & attach): _____

HOME INFUSION THERAPY

DRUG: _____ ROUTE: ☐ PERIPHERAL IV OR ☐SUBCUTANEOUS X _____ (NUMBER OF) SITES
DOSE: ____ mg/kg = total dose _____ mg FREQUENCY: ☐ WEEKLY, Q ☐ DAYS, Q ☐ WEEKS, OTHER: _____
INFUSE OVER: _____ minutes or RATE: _____
END DATE: _____ or DURATION OF THERAPY: _____ (circle one) DOSES / WEEKS / MONTHS
DATE LAST DOSE GIVEN: _____
PRE-INFUSION LABS: ☐ N/A
- ☐ Labs: _____
- ☐ Frequency: _____

SPECIFIC ADMINISTRATION INSTRUCTIONS: ☐ N/A
- ☐ Administer infusion per manufacturer guidelines
- ☐ Other (if applicable)_____

NURSING ORDERS

☐ Infusion nurse visits to administer medication and assess & educate patient
- ☐ Infusion nurse to start and remove peripheral IV access
- ☐ Flush venous access with ____ ml of 0.9% NaCl before and after med administration, as appropriate

☐ 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 monitor patient for at least ____ minutes post infusion for any reactions
☐ 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.