

**Traditional Therapy
IV INFUSION
PATIENT REFERRAL FORM**

Referral Fax: (304) 244-7001
Referral Email: allied@homeinfusion.com
Phone: (304) 974-3340

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: <input type="checkbox"/> M <input type="checkbox"/> F
MRN:	PHONE:	ALLERGIES:	
ADDRESS:			
PRIMARY DIAGNOSIS & CODE:		Face-to-Face Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No	HT: _____ <input type="checkbox"/> cm <input type="checkbox"/> in WT used to calculate dose: _____ <input type="checkbox"/> kg <input type="checkbox"/> lb
Freedom of Choice discussed w/ Patient: <input type="checkbox"/> Yes <input type="checkbox"/> No		Office visit date: _____	
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? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes - DATE/TIME OF LAST DOSE (if applicable): _____			
LINE INSERTION DATE: _____			
LINE TYPE: _____ # of Lumens: _____ Gauge: _____			
LABS: <input type="checkbox"/> N/A <input type="checkbox"/> Follow OPAT GUIDELINES FOR LABS AND FREQUENCY			
<input type="checkbox"/> Other Labs: _____			
<input type="checkbox"/> Frequency: _____			
LINE MAINTENANCE AND FLUSHING:			
<input type="checkbox"/> Per AHS Home Infusion standing orders			
<input type="checkbox"/> Other: _____			
SPECIFIC ADMINISTRATION INSTRUCTIONS (if applicable): _____			
NURSING ORDERS			
<input type="checkbox"/> Infusion nurse visits to administer medication, assess and educate patient. <input type="checkbox"/> Line and site care per AHS Guidelines and nursing agency policy and procedure. <input type="checkbox"/> Stop infusion if hypersensitivity or infusion-related reaction develops. <input type="checkbox"/> Follow provider's EMERGENCY MEDICATION orders and nursing agency policy and procedure for anaphylactic /adverse reaction and notify provider. <input type="checkbox"/> Educate patient on s/s of reaction and to seek medical attention including emergency care 911, if symptoms occur. <input type="checkbox"/> 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.			

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments. Patient privacy is important to us. Our employees are trained regarding the appropriate way to handle patient's private health information. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with Allied Health Solutions Specialty Pharmacy and/or its affiliates.