Seminole Hospital District
INFUSION CENTER
Phone: 432-758-4716 Fax: 877-249-1191

☐ **STAT REFERRAL**

GENERAL IV ORDER FORM

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________ MI_______ DOB:______________

HT: _________ in WT: ________ kg Birth Sex :( ) Male ( ) Female Allergies: ( ) NKDA, (Or):______________________________

____

Provider Name______________________ Contact Name ________________ Contact Phone # ________________

NPI #:______________________ Tax ID #:______________________ Fax #: ______________________

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD 10 CODE + DESCRIPTION)

____

Secondary Diagnosis: (ICD 10 CODE + DESCRIPTION)

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Does patient have venous access? ☐ **YES** ☐ **NO** **If yes, what type** ☐ **MEDIPORT** ☐ **PIV** ☐ **PICC LINE** ☐ **OTHER:**______________

PRESCRIPTION ORDERS

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH SALINE PER HOSPITAL PROTOCOL PRN UNLESS OTHERWISE NOTED BY PROVIDER
b) BIOSIMILAR EQUIVALENT SUBSTITUTION MAY APPLY

PLEASE SELECT FROM BELOW:

______ Perform port flush every ________ weeks per hospital protocol.
______ Perform IV site care per hospital protocol.
______ Cathflo Activase 2mg IVP per hospital protocol.

NOTE: For patients with central venous access, please select: ☐ **DISCHARGE AFTER LAST DOSE**

DRUG 1	**DOSE**	**ROUTE**	**FREQUENCY**	**DURATION**
DRUG 2	**DOSE**	**ROUTE**	**FREQUENCY**	**DURATION**
DRUG 3	**DOSE**	**ROUTE**	**FREQUENCY**	**DURATION**
DRUG 4	**DOSE**	**ROUTE**	**FREQUENCY**	**DURATION**

LABS

SELECT BELOW	LAB REQUESTED	FREQUENCY
	NONE	NA
	CBC w/ Diff	
	BMP	
	CMP	
	BUN/CREATININE	
	ESR	
	CRP	
	CPK	
	Other:	
	Other:	

NOTES/INSTRUCTIONS/OTHER

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____
____
____
____
____
____
____

Physician's Signature ______________________________ **Time**______________ **Date**______________
**Signature Must Be Clear and Legible*

Cosignature (If Required)______________________________ **Time**______________ **Date**______________
**Signature Must Be Clear and Legible*

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.