TEXASINFUSION

1935 W. State Street STE 103
Garland, TX 75042
Ph: 972-372-7987
Fx: 972-787-1492

IV INFUSION REFERRAL FORM

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Weight: _____kg ; Height: _____ in

DIAGNOSIS AND ICD 10 CODE
☐Dx: _____ ICD 10 Code: _____
☐Dx: _____ ICD 10 Code: _____

PRE MEDICATION	
☐ Diphenhydramine PO 25-50mg 30 min before inf	☐ IV SoluMedrol 125mg slow IVP 5 min prior to infusion
☐ Acetaminophen PO 650g 30 min before infusion	☐ IV Diphenhydramine 50mg slow IVP 5 min prior to infusion
☐ IV 0.9% Sod Chl 1,000mL pre or post infusion PRN	☐ IV Prochlorperazine 5mg slow IVP 5 min prior to infusion
☐ IV 5% dextrose in water 500mL pre or post Inf	☐ IV Ondansetron 8mg slow IVP 5 min prior to infusion

MEDICATION ORDERS
Nursing Orders: Start/Pause/Discontinue Peripheral or central IV line, Flush with 10-20mL Saline Flush (If Central line, add Heparin 500u/5ml as FINAL flush as needed. Pharmacy to dispense DME pump as needed to infuse.
Anaphylaxis kit per pharmacy protocol (IM .3mg Epinephrine, IV 50mg Diphenhydramine, and IV 1L 0.9% NS)
Refills: ☐ X 1 year ☐ _____ doses

PRESCRIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

By signing, I authorize Texas Infusion to act as an agent to initiate and execute the insurance authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time in writing via email to pharmacy@texasinfusion.com

PLEASE FAX SIGNED FORM TO 972-787-1492

UPDATED: 12-28-2023