TwelveStone HEALTH PARTNERS™

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IV THERAPY REFERRAL FORM

FAX THIS FORM ALONG WITH PATIENT DEMOGRAPHIC SHEET, RECENT CLINIC NOTES, PICC/MIDLINE REPORT, LABS AND MEDICATION LIST TO (800) 223-4063 OR (615) 278-3355.

REQUESTED FROM:

Hospital/Office Name ______________________ Phone ______________

Hospital/Office Contact ______________________ Fax ______________

PATIENT INFORMATION AND PHYSICIAN'S ORDERS:

Patient Name ______________________ DOB ________ Sex ☐ M ☐ F

Height ________ Weight ________ Allergies ______________ Diagnosis ______________

PICC Line ____________ ☐ Single Lumen ☐ Double Lumen Midline ____________ Port ____________

	Anti-Infective Therapy 1		**Anti-Infective Therapy 2**	
Therapy Ordered	☐ Vancomycin ☐ Ceftriaxone ☐ Cefepime ☐ Daptomycin ☐ Other:	Dose ________ Frequency ________ Start Date ________ Duration ________	☐ Vancomycin ☐ Ceftriaxone ☐ Cefepime ☐ Daptomycin ☐ Other:	Dose ________ Frequency ________ Start Date ________ Duration ________
Labs	☐ BMP, CBC w/differential q Tuesday ☐ Trough level after 3rd dose and with Bi-Weekly routine labs if Vancomycin or Aminoglycoside. ☐ Other:			
Flushing	☐ Flush each lumen with 10–20ml of NS before and after medication and lab draws from IV catheter. May flush PRN. Flush with 3ml of Heparin 100 units/ml after each medication. May flush PRN.		Patient has signed a DNR ☐ Yes ☐ No HH to provide PICC care, draw labs and pull line at end of therapy. May provide PRN visit for PICC care. ☐ Yes ☐ No	

First dose to be administered at hospital ☐ Yes ☐ No Labs drawn prior to first dose ☐ Yes ☐ No

Home Health Agency ______________________________

Following Physician ______________________ Phone ______________

Ordering Physician ______________________ Phone ______________

Physician Signature ______________________ Date ______________