TwelveStone Health Partners
Fax Referral To: (800) 223-4063
Direct Phone: (615) 278-3350
Toll Free: (844) 893-0012

IV THERAPY ENROLLMENT FORM

Hospital Office Name: _____ Hospital Office Contact: _____

Phone: _____ Fax: _____

Date: _____ Patient Name: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female 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 Monday
- ☐ Trough level 30 min prior to 4th dose and weekly thereafter, if Vancomycin or Aminoglycoside.
- ☐ CPK weekly, if Daptomycin
- ☐ Pharmacy to dose
- ☐ 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, IC or IS to provide PICC care, draw labs and pull line at end of therapy. ☐ Yes ☐ No

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.

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: _____

CLINICAL LIAISONS & CONTACTS

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Intake- (844) 893-0012 Ext. 1