Health First Infusion

Fax to: (888) 978-7869
1959 W. 9th Street, Suite A
West Palm Beach, FL 33404
Phone: (800) 499-6579

Home Infusion Referral Form

Patient Information

Patient Name:	DOB:	Sex: ☐ M ☐ F
Address:		Phone #:
City/State/Zip:		Employer:
Primary Diagnosis:		ICD-10 Code:
Weight: ☐ lbs ☐ kg Height:	Diabetic: ☐ Yes ☐ No	
Allergies:		
Primary Insurance:		Phone #:
Name of Insured:		Relationship:
SSN:	DOB:	Employer:
Group #:		Policy #:
Secondary Insurance:		Phone #:
Name of Insured:		Relationship:
SSN:	DOB:	Employer:
Group #:		Policy #:

Therapies

Check all that apply

☐ Antibiotic	☐ Antifungal	☐ Antiviral	☐ Enteral Nutrition
☐ Hydration	☐ IgG	☐ Inotrope	☐ Pain Management
☐ Parenteral Nutrition	☐ Other:		

Other:

Pharmacy Orders

IV Access: ☐ PICC ☐ Groshong ☐ Hickman ☐ Port-a-cath ☐ Peripheral ☐ Other: # of lumens:

Medication/Dose 1:	Notes:
Medication/Dose 2:	Notes:

Delivery Method: ☐ Gravity ☐ IV Push ☐ Pump ☐ SQ ☐ IM ☐ Other:

Flush Orders: ☐ Flush with 0.9% NaCl and Heparin 10u/ml or 100u/ml PRN as per protocol.

☐ Other flushing orders:

Other Pharmacy Orders:

Nursing/Home Health Orders

☐ IV Nursing ☐ Wound Care/Wound V.A.C. ☐ Physical Therapy ☐ Other:

Notes:

Lab Orders:

☐ CBC-DIFF	☐ BMP	☐ CRP	☐ SED RATE
☐ VANCO-TROPH LEVEL	☐ OTHER:		

Physician Information

Physician Name:	License#:	NPI#:
UPIN#:	Office Contact:	Phone #
Prescriber Signature:	Date:	Time: