KabaFusion FL
Patient-Focused Infusion Therapy

Return Signed RX via Fax to 561.353.4666

KabaFusion Enteral Referral Form

To: Karen Kaczmarek, Pharm.D.	From:		
Intake Phone: **561.353.4663**	Phone:	Fax:	
Date:	Number of Pages, Including Cover:		
Patient Name:	Home Phone:		
Date of Birth:	Name of Clinic:		
Patient Home Address:	City:	State	Zip
Diagnosis:		Gender : ☐ Male	☐ Female
Are TPN Orders attached to this Referral Form ☐ Yes ☐ No	First Dose? ☐ Yes	☐ No	
Patient Eating? ☐ Yes ☐ No	Estimated Length of Therapy:		
IV Access: ☐ PICC ☐ Port ☐ Central ☐ Other	Pump Required? ☐ Yes	☐ No	
Hospital Discharge Summary attached? ☐ Yes ☐ No	Most Recent Labs (date):	☐ ☐ Attached:	
Anticipated Start of Care Date:	Delivery Due Date:		
Start of Care Date:	Spanish-speaking Only ☐		
History & Physical ☐ Attached	Marital Status: ☐ S ☐ M ☐ D ☐ W	Diabetic? ☐ Yes	☐ No
HT:	WT:	Allergies:	
Other home health care needs?			
Physician signing discharge orders:	Fax:	Phone:	
Physician who will follow patient at home (if different than above):			
Physician Name:	Fax:	Phone:	
Patient demographics: ☐ Attached	Patient Cell Number:	Patient Work Number:	
Delivery address (if different than home):			
Emergency Contact Outside Home:	Relationship:	Phone:	
Caregiver Name:	Caregiver Teachable? ☐ Yes ☐ No	Phone:	
Patient Independent? ☐ Yes ☐ No	Homebound? ☐ Yes ☐ No	Patient Teachable? ☐ Yes	☐ No
Insurance:	ID#	Phone:	
Medi-Cal ID#:	Issue Date:		
Medicare D? ☐ Yes ☐ No	Part D Plan:	ID#:	Phone:
Is Initial Nutrition Assessment to be provided by a KabaFusion Registered Dietitian? ☐ Yes	☐ No		

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