



Return Signed RX via Fax to 773.775.2732

## IV Antibiotic Referral Form

To: Pharmacy	From:
Intake Number: <b>800.831.7740</b>	Phone Number:
Date:	Number of Pages, Including Cover:
<b>Patient Name:</b>	<b>DOB:</b>
<b>Diagnosis/ICD-10:</b>	<b>Allergies:</b>

**Initiation/Continuation of infusion therapy orders (drug, dose, rate, duration and frequency):**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

IV Access Device (check one):  Peripheral  Central  Flush IV access device with heparin/saline per KabaFusion protocol

Supplies/Pump/Pole as appropriate to administer ordered therapy: \_\_\_\_\_

Anaphylaxis Kit – EpiPen Auto-injector use as directed. 2 Pak Kit PRN, refill x 1 year

Laboratory Orders: \_\_\_\_\_

Additional Comments/Orders: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Prescriber Name: \_\_\_\_\_ NPI#: \_\_\_\_\_

Please fax the following information:

Patient Demographics – include insurance information. **We will obtain authorization** unless the insurance dictates otherwise

H & P **OR** progress note(s) describing diagnosis and clinical status

Recent Laboratory Results

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