Complete Infusion Care

2310 South Sepulveda Blvd.

Los Angeles, California 90064

Phone: (310) 836-6666 Fax: (310) 836-6675

MEDICAL REFERRAL FORM

Patient Name:_____D.O.B._____Gender: M F HT:_____in WT: _____LB

Address:_____City:_____State:_____Zip Code:_____

Phone ( )_____ ALLERGIES:_____DIAGNOSIS:_____

PLEASE LIST ALL FAILED MEDICATIONS RELEVANT TO THE DIAGNOSIS:_____

PLEASE COMPLETE THE FOLLOWING AND FAX COPY OF PATIENT'S LAB REPORTS

Anti-biotics: ADULT DOSE(Circle and/or Check)

- ☐ CUBICIN (Daptomycin) (4 TO 6 mg/kg) _____mg IVPB ONCE DAILY FOR (2 TO 6 Weeks) _____Weeks
- ☐ INVANZ (Ertapenem) 1 GM IVPB Once Daily for (3 to 14 Days) _____Days
- ☐ ROCEPHIN (Ceftriaxone) (1 to 2 g)_____g IM or IVPB Once Daily (MAX=4 G /DAY) for (1 , 2 , 3, to 8 weeks) _____Weeks
- ☐ VANCOMYCIN 1 g IVPB q12h or q24h Dose per Pharmacy: Need Base Line Labs Drawn; CBC, and CMP
- ☐ ***OTHER:*** ***SIG:*** ***DURATION:*** ***REFILLS:***

DRUG: DIRECTIONS: DURATION:

Anti-Coagulation Medication: (Circle and/or Check)

- ☐ LOVENOX (Enoxaprin) (40 mg, 60 mg, 80 mg, or _____mg) SubQ Inj daily x (10 or 14 days or _____days)
- ☐ FRAGMIN (Dalteparin Na) (2500 or 5000 units 10 to 14 hrs Pre-Op) and (2500 or 5000 units 4 to 8 hrs Post-Op) then 5000 units once daily for (5 , 10, 14 days or _____ days)
- ☐ ARIXTRA (Fondaparinux) (5 mg = Pt Wt less than 50 kg)or(7.5 mg = 50 to 100 kg) or (10 mg = more than 100 kg) Subcutaneously Once Daily For (5 , 9, UP TO 26 OR _____DAYS
- ☐ ***OTHER :*** ***SIG:*** ***DURATION:*** ***REFILLS:***

DRUG: DIRECTIONS: DURATION: REFILLS:

Total Parenteral Nutrition

- ☐ IV Over ____ HRS
- ☐ VIA_____(access)
- ☐ Daily x (months)

Enteral

- ☐ Brand: _____

____ML Over ___HRS

IVIG:

- ☐ IVIG Name: _____

Dose_____Grams

Frequency_____

Length of Therapy_____

# of Refills _____

Anti-Emetics:

- ☐ Prochlorperazine 2.5 to 10 mg :_____mg by slow IV injection or infusion at a max rate 5 mg/min. every 3 or 4 hours for _____days
  Maximum dose: 10 mg (single dose); 40 mg/day (total daily dose).
- ☐ Promethazine 25 to 50 mg DEEP IM or IV MAX = 100 mg / DAY
- ☐ Zofran (Ondanstron) 4, 8, or 16 mg IVPB OVER 30 MIN ONCE, TWICE, OR THREE TIMES DAILY
- ☐ Anzemet (Dolasetron) 12.5 mg IV given as a single dose approximately 15 minutes before the cessation of anesthesia or as soon as nausea or vomiting presents
- ☐ Aloxi (Palonosetron)A single 0.25 mg intravenous (IV) dose administered over 30 seconds. Dosing should occur approximately 30 minutes before the start of chemotherapy

Other : ***Sig:*** ***Duration:*** ***Refill:***

Doctor Name:_____

Street Address:_____City:_____State:_____Zip Code:_____

Telephone number: ( ) _____ Fax: ( )_____

DEA #_____State Lic # _____NPI #:_____

Signature:_____Date:_____