Upstate HomeCare

The Best for Getting Better

Infusion Referral Intake Form

Phone: (888)648-2211 Fax: (315)580-4297

FAX

To: Upstate HomeCare Intake **Fax#:** 315-580-4297

From: (Name) (Location) (Phone#)

RE: New Referral **Pages:**

Patient Name:

Referral Checklist - Please Attach the Following

☐ **Demographics** ☐ **H&P Progress Notes** ☐ **Prescriptions**

Referral Information

Diagnosis:

Allergies: Height: Weight:

First Dose: ☐ Yes ☐ No **Access:** ☐ None ☐ Type:

Therapy Ordered

Drug: **Dose:** **Freq:** **Duration:** **Start Date:**

Flushing

☐ Sodium Chloride 10ml Flushes
Use as directed
#100 with 11 refills

☐ Heparin 5 ml Lock 10 u/ml
Use as directed
#100 with 11 refills

☐ Heparin 5 ml Lock 100 u/ml
Use as directed
#100 with 11 refills

Labs

☐ CBC w/differential ☐ CMP ☐ CRP ☐ Chem 8

☐ Trough after _____ dose; then weekly on _____

☐ Other: _____

☐ Forward Results to: _____

E-scribe: Upstate HomeCare

MD Following:

Nursing Agency: