



Center for Infusion Care

Phone: (517) 212-4336 | Fax: (877) 249-1191
 hillsdalehospital.com/infusion

STAT REFERRAL

GENERAL IV ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI _____ DOB: _____
 HT: _____ in WT: _____ kg Sex: () Male () Female Allergies: () NKDA, _____

Physician Name _____ Contact Name _____ Contact Phone # _____
 NPI #: _____ Tax ID#: _____ Fax #: _____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: (ICD 10 CODE + DESCRIPTION) _____
 Secondary Diagnosis: (ICD 10 CODE + DESCRIPTION) _____

Does patient have venous access? YES NO If yes, what type MEDIPORT PIV PICC LINE OTHER: _____

PRESCRIPTION ORDERS

a) ALL MEDIPORTS / IV ACCESSES WILL BE FLUSHED WITH HEPARIN OR SALINE PER HOSPITAL PROTOCOL PRN

PLEASE SELECT FROM BELOW:

- _____ Perform port flush every _____ weeks per hospital protocol.
- _____ Perform IV site care per hospital protocol.
- _____ Activase 2mg IVP per hospital protocol.

NOTE: For patients with central venous access, please select: D/C AFTER LAST DOSE

DRUG 1	DOSE	ROUTE	FREQUENCY	DURATION
DRUG 2	DOSE	ROUTE	FREQUENCY	DURATION
DRUG 3	DOSE	ROUTE	FREQUENCY	DURATION
DRUG 4	DOSE	ROUTE	FREQUENCY	DURATION

LABS			NOTES/INSTRUCTIONS/OTHER
SELECT BELOW	LAB REQUESTED	FREQUENCY	
	NONE	NA	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____
	CBC w/ Diff		
	BMP		
	CMP		
	BUN/CREATININE		
	ESR		
	CRP		
	CPK		
	Other:		
	Other:		

Physician's Signature _____ Time _____ Date _____
 *Signature Must Be Clear and Legible

Cosignature (If Required) _____ Time _____ Date _____
 *Signature Must Be Clear and Legible

Fax completed form, supporting documentation, facesheet, and insurance cards to the Outpatient Infusion Center at 1 (877) 249-1191.