

Generic Prescriber Order and Referral

Pharmacists with the Froedtert Pharmacy will be supporting this patient's infusion medication management.
Fax completed form, insurance information and clinical documentation to 414-260-7368.

Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Height: _____ inches cm Weight: _____ lbs kg

Clinical Information

Primary Diagnosis Description: _____ ICD-10 Codes: _____

Allergies _____

Prescription

Please indicate medication, dose, frequency, route and length of therapy:

Ancillary Orders

Anaphylaxis Orders

Treat per Froedtert Home and Specialty Infusion protocol.

Medication Orders

Acetaminophen 650 mg PO 30 min before infusion. Patient may decline.

Diphenhydramine 25 mg PO 30 min before infusion. Patient may decline.

Other: _____

IV Access and Flush Orders: RN to access and monitor venous infusion line as indicated below:

Peripheral: Flush with 0.9% NS - 10 ml pre/post-use.

Implanted Port or PICC: Flush with 0.9% NS - 10 ml pre/20 ml post-use and 10 ml pre/20 ml post-lab draw.

Lab Orders

No labs ordered at this time.

Other: _____

Skilled nurse to administer doses intravenously in the home or alternate care setting. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature _____ Date _____ Time _____

Prescriber Name _____ Phone _____ Fax _____

Address _____ NPI _____

City, State, Zip _____ Office Contact _____

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Original - Medical Records

Froedtert Home and Specialty Infusion
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