Indiana University Health

General Home Health Infusion Referral

To: IU Health Home Care *infusionhomecare@iuhealth.org* **Fax (317) 962-4737 * Phone (317) 963-4919**	***For NON-IU HEALTH physician referrals, please attach patient demographics, insurance, and clinic notes.***
From: **Phone:** **Fax** :	**Today's Date:** **ICD-10/Diagnosis:**
Patient Name: **DOB:** **MRN:**	**Patient Weight:** _____**kg or**_____**pounds** **Patient Height:** _____**cm or**_____**inches**

☒ **Home Infusion Therapy and Skilled Nursing Visits** for *Administration/Assessment / Education*	
Drug Order (Dose, Frequency, length of need)	
Has patient had this drug before?	☐ Yes ☐ No
Premedications:	☐ Methylprednisolone 100mg 50mg x 1, 30 minutes prior to infusion ☐ Hydrocortisone ☐ 100mg ☐ 200mg x 1, 30 minutes prior to infusion ☐ Diphenhydramine ☐ 25mg ☐ 50mg, ☐ PO ☐ IV x 1, 30 minutes prior to infusion ☐ Acetaminophen 650mg PO x 1, 30 minutes prior to infusion ☐ Other_____
Hypersensitivity Reaction/Treatment	☒ IUHHC Anaphylaxis Adverse Drug Reaction Protocol if required per Home Care Approved Medication policy. Pharmacy to dispense epinephrine, diphenhydramine, and Normal Saline per IUHHC protocol
IV Access	☐ PIV - RN to place peripheral line at home and discontinue once IV therapy completed ☐ Port – supplies and flushes per IUHHC catheter maintenance protocol ☐ Tunneled CVL - supplies and flushes per IUHHC catheter maintenance protocol ☐ PICC - supplies and flushes per IUHHC catheter maintenance protocol ☐ Other _____
Labs	☐ Labs and frequency_____

Physician Name (printed)_____

Physician Signature_____Date _____

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