MEMORIAL HERMANN Home Care

GENERAL PRESCRIPTION REFERRAL FORM

Please sign and fax completed form to 281.698.6147
If you have questions, please call 281.698.6175

PATIENT INFORMATION

Patient Name:	DOB:
Street Address:	☐ Male ☐ Female
City, State, ZIP:	
Primary Phone:	Alt. Phone:
Email Address:	Patient's primary language:

PRESCRIBER INFORMATION

Prescriber Name:	☐ MD ☐ DO ☐ NP ☐ P
Specialty:	NPI #:
Office Contact:	DEA #:
Email:	
Phone:	Fax:
Office Address:	Preferred Method of Contact ☐ Email ☐ Phone ☐ Fax
City, State, ZIP:	

CLINICAL INFORMATION

Diagnosis (ICD-10)		**Medical Information**
Primary ICD:	Description:	Type of Access to be used:
Other ICD:	Description:	Allergies:
Treatment History		Current weight:_____ kg / height:_____ cm
Has patient been treated previously for this condition? ☐Yes ☐No		Please include copy of current medication profile if available.
Will this be a first does? ☐ Yes ☐ No		

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	FORMULATION	DIRECTIONS	QTY	REFILLS

☐ Home Health to evaluate and treat for home infusion

Pre-Medications To be administered 30 minutes prior to starting the infusion.

☐ Tylenol _____mg by mouth o Antihistamine: (please choose one) _____mg Benadryl by mouth _____mg Benadryl IV or ____mg Loratadine by mouth

Additional Pre-Medication Orders: ☐ Solu-Medrol _____mg IV push ☐_____ ☐ _____

Line Care

☐Flush with 10mL 0.9% Sodium Chloride before and after each medication, followed by 5mL Heparin 10 units/mL using the SASH method. (Heparin not needed for Groshong access device.)

☐Other Line Care: _____

Laboratory Work and Frequency (please identify any appropriate lab work that is needed that pertains to this treatment.
Please specify the test and frequency. _____

Reaction Management STOP infusion immediately. Administer reaction management medications. Call 911 as appropriate and notify Physician _____Phone _____ immediately for any new onset of the following life threatening hypersensitivity reactions to include fever, chills, dyspnea, pruritus, urticarial, convulsions, erythematous rash, hypotension, back pain, sudden chest pain or hypertension.

- Acetaminophen (Tylenol) 500MG by mouth every 4 hours PRN myalgia or fever > 101.3.
- Diphenhydramine (Benadryl) 25MG IV every 4 hours PRN urticarial, pruritus, or shortness of breath.
- If symptoms are rapidly progressing or continue after the diphenhydramine: give epinephrine (1:1,000 strength) 0.3mL subcutaneously. May repeat every 10-15 minutes at a maximum of 6 doses.
- Other:_____

By signing below, I authorize Memorial Hermann Home Health Pharmacy and its representatives to serve as my designated agent if needed, to initiate and execute any applicable authorization processes with medical and prescription insurance companies.

Prescriber's Signature:_____ Date:_____

(signature required – NO STAMPS)

In order for a brand name product to be dispensed, the prescriber must handwrite **"Brand Necessary"** or **"Brand Medically Necessary"** on the prescription.