

An Outpatient Department of Trinity Health Oakland
9406 Village Place Blvd, Brighton, MI 48116
Phone: 810-844-7373
Fax: 810-844-7366

General Referral/Order Form

Along with this order form, please include the following: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. ArrIVE Infusion will obtain any necessary medication authorizations for patients receiving infusion therapies.

Order Date: ____/____/____

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Renewal

<p>Patient Name: _____</p> <p>Patient Address: _____</p> <p>Patient Phone Number: _____</p> <p>Date of Birth: ____/____/____</p> <p>Weight: ____ kg Height: ____ cm</p> <p>Allergies: _____</p>	<p>Primary Insurance: _____</p> <p>Member ID: _____</p> <p>Secondary Insurance: _____</p> <p>Member ID: _____</p>
<p style="text-align: center;">Diagnosis</p> <p>Diagnosis Code (ICD-10): _____</p> <p>Indication: _____</p> <p>Target start date: _____</p>	<p style="text-align: center;">Lab Orders</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><input type="checkbox"/> No labs required</p> <p><input type="checkbox"/> BMP</p> <p><input type="checkbox"/> CBC</p> <p><input type="checkbox"/> CMP</p> <p><input type="checkbox"/> CK</p> <p><input type="checkbox"/> ESR</p> <p><input type="checkbox"/> Other: _____</p> </div> <div style="width: 45%;"> <p><input type="checkbox"/> AST/ALT</p> <p><input type="checkbox"/> BUN</p> <p><input type="checkbox"/> CBC w/ diff</p> <p><input type="checkbox"/> CRP</p> <p><input type="checkbox"/> SCr</p> </div> </div> <p style="text-align: center;">Frequency</p> <p><input type="checkbox"/> Once</p> <p><input type="checkbox"/> Daily</p> <p><input type="checkbox"/> Weekly</p> <p><input type="checkbox"/> Other: _____</p>
<p>Hold and notify provider if patient: _____</p>	
<p>Medication: _____</p> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 45%;"> <p>Dose: _____</p> <p>Frequency: _____</p> </div> <div style="width: 45%;"> <p>Route: _____</p> <p>Duration: _____</p> </div> </div>	

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Flushing Protocol <i>as needed for line care</i>	<input type="checkbox"/> Sodium Chloride 0.9% <input type="checkbox"/> 5 mL <input type="checkbox"/> 10 mL	<input type="checkbox"/> Heparin 100 Units/mL <input type="checkbox"/> 5 mL <input type="checkbox"/> 10 mL
Hypersensitivity Panel Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy as necessary	<ul style="list-style-type: none"> • Sodium chloride 0.9% bolus 500 mL once as needed for hypotensive management (SBP <90mmHg) • Acetaminophen 650 mg once as needed for temperature GREATER than 38 C (100.4 F), headaches, generalized pain, back pain, abdominal cramping • Albuterol 2.5 mg /3 mL (0.083%) nebulizer solution 2.5 mg, nebulize every 10 min PRN, hypoxemia, bronchospasm, wheezing, dyspnea, for 2 doses • Albuterol HFA inhaler 2 puffs q4hs as needed for hypoxemia, bronchospasm, wheezing, dyspnea • Epinephrine injection 0.3 mg IM every 15 minutes as needed for SBP less than 90mmHg, mild to moderate anaphylaxis for 3 doses • Famotidine injection 20 mg IV over 2 minutes once as needed for severe hypersensitivity/infusion reaction including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • Diphenhydramine injection 25 mg IV over 1 minute once as needed, moderate hypersensitivity/infusion reaction (grade 2) including temperature greater than 100.5, rigors, localized rash/hives, vomiting, nausea, pruritis, flushing, dizziness, back pain, abdominal cramping, uneasiness, agitation, feeling of impending doom • Diphenhydramine injection 50 mg IV over 1 minute once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • Hydrocortisone sodium succinate injection 100 mg IV once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure 	
<div> <div> Provider Name: _____ Office Phone Number: _____ Attending Physician Name: _____ </div> <div> Provider Signature: _____ Provider NPI: _____ Office Fax Number: _____ </div> </div> <p><i>Note: This order is valid for 12 months from date of physician signature.</i></p>		