I V Care Options Referral / PHYSICIAN ORDER
800-277-7302 (Intake Telephone #)

To: **IVCO Intake Department**	Physician Name:
Fax #: **866-374-6663**	Hospital:
Date:	Phone #:
Patient Name:	Contact:
Patient Location (at time of Referral)	☐ Home ☐ Hospital ☐ Other _____

Services Requested (Please check all that apply)

☐ Nausea & Vomiting - Ondansetron (Zofran) -- IVCO to initiate continuous Zofran SQ therapy: Zofran 2mg/ml in 50ml pump cassette via SQ set to be changed every 72 hours & PRN; Continuous rate 1mg/hr with demand dose 2mg every 6 hours prn continued nausea; May increase rate if needed to maximum continuous rate 1.2mg/hr. Total rate with PRN bolus dose not to exceed 32mg/24 hrs; IVCO nurse to instruct patient/caregiver in the placement of SQ site, changing infusion set and site every 72 hours, pump cassette changes & daily logs of Ketones(Notify MD if > 1+ for 3 days) & Weight (Notify MD if WT gain > 3lbs/day or >= 5lbs/ over 3 day period; Pharmacy to provide drug information sheet to include side effects and adverse reactions

☐ Nausea & Vomiting - Metoclopramide (Reglan) --- IVCO to initiate Reglan SQ therapy (not to exceed 12 weeks). Reglan 5mg/ml in 50ml pump cassette via SQ set to be changed every 72 hours and PRN; Continuous rate 1mg/hr with a PRN bolus dose of 2mg every 12 hours; May increase rate if needed to maximum continuous rate of 2.5mg/hr. (Total Rate plus PRN bolus dose not to exceed 70mg/24 hrs (60mg + 10mg PRN); IVCO nurse to instruct patient on the placement of SQ site, cassette changes, daily weight, and ketone log (notify MD if > 1+ for 3 days); Pharmacy to provide drug information sheet to include side effects and adverse reactions; Patient to weigh daily (notify MD if weight gain >= 3 lbs/day or >=5 lbs over 3 day period

Hydration Therapy

☐ D5 0.9% NS IV at 125ml/hr for 2 liters/day for _____ days

☐ Lactated Ringers IV at 125ml/hr for 1 liter/day for _____ days

☐ Lactated Ringers IV at 125ml/hr for 2 liters/day for _____ days

☐ Other _____

TPN Therapy (Recent labs required)

☐ Orders to be written by IVCO Pharmacist based on recent lab results

☐ Procalamine

☐ Clinimix

☐ Orders attached

☐ Other Therapy

Physician Statement: My signature below certifies that this patient is under my care and in need of the above medical services. This document shall serve as physician orders.

Physician Name: _____

Physician Signature: _____

Stamped Signatures are Not Acceptable

Physician NPI: _____

Please attach the following documents with your referral submission

Face Sheet/Demographic Sheet; H&P, Progress notes, Front and Back of Insurance Card

Has request for service been discussed with patient? o Yes o No

Does IVCO have permission to contact the patient? o Yes o No

Additional Comments:

THANK YOU FOR YOUR REFERRAL; IVCO WILL CONTACT YOU ASAP WITH THE STATUS