

Home Start PN Referral Form



Fax completed form to:

| PATIENT INFORMATION | | | | | |
|---|------------------|-------------------|--------------------------|------|--------|
| Patient Name: | Date of Birth: | | Referral Date: | | |
| Address: | | | City/State/Zip: | | |
| Home Phone: | Cell Phone: | | Work Phone: | | |
| Secondary Contact: | Height: | Weight (current): | Weight (six months ago): | Male | Female |
| Allergies: | | | | | |
| Patient Diagnosis & ICD-10: | | | | | |
| Type of Vascular Device: | | # Lumens: | Date Placed: | | |
| PROVIDER INFORMATION | | | | | |
| Physician Name: | Lic.#: | | DEA #: | | |
| Practice Name: | | | NPI#: | | |
| Address: | | | City/State/Zip: | | |
| Office Contact: | Phone: | | Fax: | | |
| Supervisory Physician (if applicable): | | | | | |
| PHARMACY ORDERS | | | | | |
| Initiate Home PN. Dietitian or Pharmacist to provide recommendations for PN formula for physician review and approval. Dietitian or Pharmacist to help manage ongoing PN therapy and changes in formula according to labs and patient assessment. | | | | | |
| LAB ORDERS | | | | | |
| Prior to PN initiation: Complete Metabolic Profile, Magnesium and Phosphate levels | | | | | |
| PN Day : _____ Complete Metabolic Profile, Magnesium and Phosphate levels | | | | | |
| PN Day : _____ Complete Metabolic Profile, Magnesium and Phosphate levels, CBC, Triglycerides, Prealbumin, and CRP | | | | | |
| Weekly: Complete Metabolic Profile, Magnesium and Phosphate levels, and CBC | | | | | |
| Monthly: Complete Metabolic Profile, Magnesium and Phosphate levels, CBC, Triglycerides, Prealbumin, and CRP | | | | | |
| Designate who will draw the labs on: | | | | | |
| Pre PN initiation: | Physician office | Home Health | | | |
| Day _____: | Physician office | Home Health | | | |
| Day _____: | Physician office | Home Health | | | |
| Weekly and Monthly Labs: | Physician office | Home Health | | | |
| MONITORING | | | | | |
| Other Labs: | | | | | |
| Other Home Monitoring: Daily Weights, Daily Temperature Monitoring, s/s IV catheter related complications, and s/s fluid imbalance. | | | | | |
| Diet: NPO Clear Liquid As tolerated Other (specify) | | | | | |
| Nursing Orders: Visit Frequency: 3x/wk x 1 week; then weekly for VAD care, labs and education management. May make prn visits as needed. | | | | | |
| Face to Face Documentation: Last Patient Visit with MD: | | | | | |
| Is Patient Homebound? Yes No | | | | | |
| Homebound Status: It requires a taxing effort for patient to leave home due to: | | | | | |
| (dx) and the following signs and symptoms: | | | | | |
| <i>By signing this form and utilizing our services, you are authorizing Amerita, Inc. to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.</i> | | | | | |

Prescriber's Signature
Dispense as Written

Print Name **Date**

Prescriber's Signature
Substitution Permitted

Print Name **Date**

