Parenteral Nutrition Referral Form

Fax Completed Form To: **Phone:**

Amerita
YOUR INFUSION ADVOCATE

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:

By signing this form and utilizing our services, you are authorizing Amerita to assist with prior authorization requests acting as your pharmacy provider in dealing with medical and prescription insurance companies.

Prescriber's Signature **Print Name** **Date**
Dispense as Written

Prescriber's Signature **Print Name** **Date**
Substitution Permitted

ameritaiv.com

AME_Parenteral Nutrition Referral Form 7.31

THIS FORM IS NOT VALID FOR USE IN THE STATE OF ARIZONA.

ACHC ACCREDITED
PCAB ACCREDITED Compounding Pharmacy