vitalcare of SOUTH DALLAS

PEDIATRIC PATIENT REFERRAL FORM

P: 945.212.3707 | **F:** 866.790.3580

☐ Home Infusion ☐ Alternate Site of Care

Legal Patient Name:	**DOB:**	**Height:**	**Weight:**	**BSA:**
ICD 10 Diagnosis Code:	**Diagnosis:**			
Allergies:				

MUST Include with Order:
- ☐ History & Physical
- ☐ Medication List
- ☐ Completed Prior Authorization (if required)
- ☐ Patient Demographics & Insurance
- ☐ Consent **REQUIRED** if ordering Blood Products and/or Chemotherapy

MEDICATION ORDERS

Name	Dose	Route	Frequency	Duration
	☐ ________ mcg ☐ ________ mg ☐ ________ gram ☐ ____________	☐ IV ☐ IM ☐ SC ☐ PO	☐ Daily ☐ Weekly ☐ Monthly ☐ Every _____ Months ☐ PRN ☐ Other ____________	☐ Once ☐ One Year ☐ Other ________________ ______________________ ______________________ ______________________
	☐ ________ mcg ☐ ________ mg ☐ ________ gram ☐ ____________	☐ IV ☐ IM ☐ SC ☐ PO	☐ Daily ☐ Weekly ☐ Monthly ☐ Every _____ Months ☐ PRN ☐ Other ____________	☐ Once ☐ One Year ☐ Other ________________ ______________________ ______________________ ______________________
	☐ ________ mcg ☐ ________ mg ☐ ________ gram ☐ ____________	☐ IV ☐ IM ☐ SC ☐ PO	☐ Daily ☐ Weekly ☐ Monthly ☐ Every _____ Months ☐ PRN ☐ Other ____________	☐ Once ☐ One Year ☐ Other ________________ ______________________ ______________________ ______________________
	☐ ________ mcg ☐ ________ mg ☐ ________ gram ☐ ____________	☐ IV ☐ IM ☐ SC ☐ PO	☐ Daily ☐ Weekly ☐ Monthly ☐ Every _____ Months ☐ PRN ☐ Other ____________	☐ Once ☐ One Year ☐ Other ________________ ______________________ ______________________ ______________________
	☐ ________ mcg ☐ ________ mg ☐ ________ gram ☐ ____________	☐ IV ☐ IM ☐ SC ☐ PO	☐ Daily ☐ Weekly ☐ Monthly ☐ Every _____ Months ☐ PRN ☐ Other ____________	☐ Once ☐ One Year ☐ Other ________________ ______________________ ______________________ ______________________

CENTRAL LINE CARE

To order Heparin, check below:
- ☐ FOR PORT: Heparin > 20 kg / 500 units / 5 ml < 20 kg 300 units / 3 ml
- ☐ FOR PICC: Heparin 250 units/ 2.5 ml per lumen
- ☐ Alteplase 2 mg IV P RN

Printed Provider Name: ____________________________________ **Office Phone:** ______________

Provider Signature: ________________________________ **Date:** ______________ **Time:** __________