Antelope Valley Medical Center
Infusion Care

Patient Referral Form

Please Fax this Form to: **661-951-4406** or email to: **Infusion_Suite_Efax@avmc.org**

This Referral is From:

☐ Doctor's Office ☐ Case Manager ☐ Liaison ☐ Skilled Facilities

Patient Name: _____ DOB: _____

Patient Address: _____

Patient Phone Number: _____

Alternate Phone Number: _____

Insurance Name: _____ ID#: _____ Group# _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Primary Diagnosis: _____

Height: _____ ☐ CM ☐ IN

Weight: _____ ☐ LB ☐ KG

Allergies: _____

Home Medications: _____

IV Access Route:

☐ Midline
☐ PICC: Number of Lumens _____
☐ Port: Huber Needle Size _____
☐ Other _____

☐ G Tube
☐ J Tube
☐ NG Tube/Dobhoff

Discharge Order (Drug, Dose, Frequency, Route, Method of Administration, Duration):

_____

First Dose: ☐ Yes ☐ No

Labs: _____

Expected Start of Care (Date & Time): _____

Is Patient Homebound (Y/N)? _____ Is Patient Current with HHA (Y/N)? _____

Ordering MD: _____ Date: _____