FAMILY PHARMACY VITAL CARE
Home Infusion Services

INTRAVENOUS MILRINONE REFERRAL FORM

Please fax completed form to Family Pharmacy Vital Care at 940-552-5347.

*Please include demographics, recent H&P, lab results, clinical notes, discharge summary, operative report, and MAR.

Patient's Name: _____ Date of Birth: _____

Phone #: _____ Allergies: _____

Primary/Secondary Insurance(s): _____

Weight: _____ Height: _____ Anticipated Date of Hospital Discharge: _____

INITIATION/CONTINUATION OF INFUSION THERAPY ORDERS (CHOOSE ONE)

☐ Milrinone 0.375 mcg/kg/min
Continuous Infusion
(24 hrs/day, 7 days/week)
Duration: 1 year

☐ Milrinone 0.5 mcg/kg/min
Continuous Infusion
(24 hrs/day, 7 days/week)
Duration: 1 year

☐ Milrinone 0.75 mcg/kg/min
Continuous Infusion
(24 hrs/day, 7 days/week)
Duration: 1 year

☐ PHARMACIST MAY RECALCULATE RATE WITH 10 LB WEIGHT VARIANCE

☐ Lab Orders: _____ Fax Results to: _____

☐ Please fax weekly assessments, updated medication profile, and lab results to prescriber's office

☐ Cathflo 2mg IV PRN for occluded catheter. Refill: PRN x 1 year

☐ Urgent Treatment Orders (Allergy and/or Anaphylaxis) per Pharmacy Protocol

☐ Initiate standing orders for peripheral IV PRN temporary access

*In addition to medication listed above, pharmacy will dispense catheter care supplies, pump, and administration supplies required for treatment including saline and heparin flush as needed.

Additional Comments:

_____

_____

_____

Prescriber's Printed Name: _____ **Phone #:** _____ **Fax #:** _____

Prescriber's Signature: _____ **Date:** _____ **NPI #:** _____