

# PULMONOLOGY REFERRAL FORM

## FAMILY PHARMACY VITAL CARE

1720 Hillcrest Drive  
Vernon, TX 76384

Phone 940-552-2999 • Fax 940-552-5347

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Pt Wt: \_\_\_\_\_ Pt Ht: \_\_\_\_\_ Pt Allergies: \_\_\_\_\_

\*Please attach Demographics page, relevant Labs, History & Physical or Progress Note, and Medications List

**Diagnosis:** \_\_\_\_\_

**Medications:**

- Cefazolin (Ancef) 2 grams IV every 8 hours
- Cefepime (Maxipime) 1 gram IV every 12 hours
- Ceftazidime (Fortaz) 2 grams IV every 8 hours
- Ceftriaxone (Rocephin) 2 grams IV every 24 hours
- Meropenem (Merrem) 1 gram IV every 8 hours
- Piperacillin/tazobactam (Zosyn) 4.5 grams IV every 8 hours
- Vancomycin IV – pharmacy to dose and manage kinetics
- Methylprednisolone (Solu-Medrol) 40 mg IV every 24 hours
- \_\_\_\_\_

Duration: \_\_\_\_\_ Quantity: #QS

End date of labs, medication, IV access: \_\_\_\_\_

**IV access:**

Place and administer medication through:

- Peripheral IV      Midline      PICC

**Anaphylaxis Protocol:**

- Anaphylaxis kit per pharmacy protocol

**IV Maintenance Protocol:**

- Dispense necessary flushes per pharmacy protocol
- Maintain IV access per Home health or pharmacy protocol

**Labs:**

- CBC w/diff      CMP      CRP      ESR      CPK      BMP      \_\_\_\_\_

Labs to be drawn on \_\_\_\_\_ then weekly thereafter

\_\_\_\_\_  
Date    Time    Signature

