Please mark closest FlexCare location:
☐ Oklahoma City, OK ☐ Norman, OK
☐ Tulsa, OK ☐ Birmingham, AL

Fax: (888) 219-8102 PH: (405) 509-6599
Email: orders@flexcareinfusion.com
Visit: flexcareinfusion.com/referrals
Contact: Cam Jones, Infusion Specialist
(443) 221-9233

PRIMARY CARE REFERRAL FORM

PATIENT INFORMATION

PATIENT NAME: ______

DATE OF REFERRAL: ______

SOCIAL SECURITY NUMBER: ______

DATE OF BIRTH: ______

PRIMARY DIAGNOSIS ICD-IO CODE: ______

HEIGHT: ____ Ft ____ In WEIGHT: ____ Lb or ____ Kg

GENDER: ☐ F ☐ M

ALLERGIES: ☐ NKDA ☐

PREFERRED CONTACT #: ______

SECONDARY CONTACT #: ______

ADDRESS: ______

CITY, STATE, ZIP: ______

FIRST DOSE: ☐ Y ☐ N NEXT DOSE DUE BY: ______

DATE OF LAST INFUSION / INJECTION: ______

ACCESS/LINE TYPE: ☐ PIV ☐ PORT ☐ PICC ☐ MIDLINE

REQUIRED DOCUMENTATION:

ALL PATIENTS

☐ Insurance Card (Front & Back) ☐ H & P
☐ Patient Demographics ☐ Most recent labs
☐ Current Medication List

PROLIA, EVENITY & ZOLEDRONIC ACID

☐ Bone Scan
☐ Most recent labs including Ca+ level within the past 3 months

INJECTAFER

☐ Most recent Ferritin, Hemoglobin, and Hematocrit

PRIMARY MEDICATION ORDER:

OSTEOPOROSIS:

☐ PROLIA 60mg subcutaneously, every 6 months
☐ EVENITY 210mg subcutaneously monthly (2 x 105mg pre-filled syringes)
☐ Zoledronic Acid 5mg IV every 12 months

IRON DEFICIENCY ANEMIA:

☐ INJECTAFER 15mg/kg IV not to exceed 1500mg on day 0 and 7 (for patients 50kg or <)
☐ INJECTAFER 750mg IV on day 0 and 7 (for patients >50kg)
☐ Infed ______ mg IV over ______ day(s)
☐ Fereheme 510mg IV on day 1 and day ______ (3-8 days after 1st infusion recommended)
☐ Other Orders:

______

______

LABS:

☐ CBC ☐ CBC with diff ☐ CMP
☐ Other: ______

FREQUENCY: ______

PRN AND PREMEDICATIONS:

	Prior to every infusion	PRN
Acetaminophen ___ mg PO	☐	☐ PRN every ___ hours after infusion.
Diphenhydramine ___ mg PO	☐	☐ PRN every ___ hours after infusion.
Diphenhydramine ___ mg diluted in 10mL 0.9% NaCl slow IV push over 2-3 min.	☐	☐ PRN every ___ hours after infusion.
Methylprednisolone ___ mg IV push over 5 minutes.	☐	☐ ______
0.9% NaCl ___ mL to infuse over ___ minutes.	☐	☐ ______

LINE USE/CARE ORDERS (if applicable)

☑ START PIV/ACCESS CVC
☐ OTHER FLUSH ORDERS:
☑ FLUSH DEVICE PER FLEXCARE INFUSION POLICY & PROCEDURE (See Reverse Side)

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

☑ ADMINISTER ACUTE INFUSION AND ANAPHYLAXIS MEDICATIONS PER FLEXCARE INFUSION POLICY AND PROCEDURE (See Reverse Side)
☐ OTHER: (please fax other reaction orders if checking this box)

PRESCRIBER INFORMATION:

PHYSICIAN NAME: ______ PHONE: ______

OFFICE CONTACT: ______ FAX: ______

ADDRESS: ______ LICENSE #: ______

CITY, STATE, ZIP: ______ NPI: ______

▶▶▶▶▶▶▶▶▶▶▶▶▶▶

PHYSICIAN SIGNATURE: ______ DATE: ______

PRIMARY CARE REFERRAL FORM

FLEXCARE INFUSION CENTER

FLEXCARE INFUSION CENTER'S ACUTE & ANAPHYLAXIS MEDICATION PROTOCOL:

**This graph does not reflect non-medicinal interventions that are part of FlexCare's protocol, such as slowing or stopping the infusion and physician/911 notification.*

	MILD INFUSION REACTION	**MODERATE INFUSION REACTION**	**SEVERE INFUSION REACTION/ANAPHYLAXIS**
SYMPTOM CLASSIFICATION	• Flushing • Dizziness • Headache • Apprehension • Diaphoresis • Palpitations • Nausea / Vomiting • Pruritis	• Chest Tightness • Shortness of Breath • Hypo/hypertension (>20 mmHg Change in Systolic BP from Baseline) • Increased Temperature (>2 Degrees Fahrenheit • Urticaria	• Hypo/hypertension (>40 mmHg Change in Systolic BP from Baseline). • Increase Temperature (>2 Degrees Fahrenheit) with Rigors • Shortness of Breath with Wheezing • Laryngeal Edema • Chest Pain • Hypoxemia
TREATMENT PROTOCOL FOR ADULTS >66LBS	☒ Administer PRN medications per Physician order	☒ Administer PRN medications per Physician order	☒ Apply oxygen via ambu bag or high flow nasal canula, if vomiting. ☒ Administer 0.9% NaCl 500 mL at 125mL/hr to maintain IV access. ☒ Administer diphenhydramine 50 mg IV or IM Inject epinephrine 0.3mg/0.3 mL IM into the mid-anterolateral aspect of the thigh; repeat in 5-15 minutes if needed. ☒ Administer 0.9%NaCl 1000mL bolus for an incomplete response to IM epinephrine. May repeat x1.
TREATMENT PROTOCOL FOR CHILDREN 33LBS - 66LBS	☒ Administer PRN medications per Physician order	☒ Administer PRN medications per Physician order	☒ Apply oxygen via ambu bag or high flow nasal canula, if vomiting. ☒ Administer 0.9% NaCl 500mL at 75mL/hr to maintain IV access. ☒ Administer diphenhydramine 1-2 mg/kg IM or slow IVP not to exceed 25 mg/min ☒ Inject epinephrine 0.15mg/0.15 mL IM into the mid-anterolateral aspect of the thigh; repeat in 5-15 minutes if needed. ☒ Administer 0.9% NaCl bolus 20mL/kg for an incomplete response to IM epinephrine. May repeat x1.

FOR CHILDREN < 33 LBS FLEXCARE INFUSION UTILIZES THE REACTION ORDERS OBTAINED BY THE REFERRING PHYSICIAN.

FLUSHING PROTOCOLS

		FLUSHING PROTOCOL Normal Saline*			**LOCKING PROTOCOL Heparin Sodium**	
		0.9% Sodium Chloride			*10 Units/mL*	*100 Units/mL*
PATIENT CLASSIFICATON	**LINE TYPE**	**PRE-ADMIN**	**POST ADMIN**	**POST LAB DRAW**	**POST NS FLUSH***	
ADULT >66 LBS	Peripheral IV Catheter	3 mL	3 mL		3 mL	
	Midline	3 mL	3 mL		3 mL	
	Implanted Port	5 mL	10 mL	10 mL		5 mL
	Peripherally Inserted Central Catheters (PICC)	5 mL	10 mL	10 mL	5 mL	
	Tunneled & non-Tunneled Catheters.	5 mL	10 mL	10 mL	5 mL	
PEDIATRIC 33 LBS - 66LBS	Peripheral IV Catheter	3 mL	3 mL		3 mL	
	Midline	3 mL	3 mL		3 mL	
	Implanted Port	5 mL	5 mL	10 mL	3 mL	
	Peripherally Inserted Central Catheter (PICC)	5 mL	5 mL	10 mL	3 mL	
	Tunneled & non-Tunneled Catheters.	5 mL	5 mL	10 mL	3 mL	

FOR CHILDREN <33 LBS, FLEXCARE INFUSION UTILIZES THE FLUSHING ORDERS OBTAINED BY THE REFERRING PHYSICIAN.

**0.9% NS will be substituted with Dextrose 5% or alternative only when indicated due to medication incompatibility with NS.*