



Kennebec
Pharmacy &
Home Care

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Augusta, ME 04330

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Intake Coordinator: Vicki Demos, RN

HOME INFUSION REFERRAL FORM

Patient Name: _____ DOB: _____

Address: _____ Phone#: _____

Insurance Co. _____ Policy#: _____

Therapy Order: _____

Start Date: _____ Duration: _____

Diagnosis: _____

Ordering Physician name:
(or signature if using this form as script) : _____

Date: _____

Type of IV Line: ___PICC ___Port ___Peripheral How many lumens? _____

Height: _____ Weight: _____ Allergies: _____

Home Health Agency: _____

*****PLEASE RETURN THIS FORM WITH THE FOLLOWING INFORMATION:**

- 1.) Patient demographics and insurance information (if not filled in above)
- 2.) List of current medications
- 3.) Central IV line procedure note and X-Ray confirmation of placement
- 4.) H & P or recent MD note describing patient condition.