

Intralipid Referral Form



Patient Preferred Clinic (select one):

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

DOB:	Patient Name:	Patient Phone:	
Patient Address:		Patient Email:	
NKDA Allergies:	Weight (lbs/kg):	Height:	
ICD-10 code (required):	ICD-10 description:	Last Treatment Date:	Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

NURSING

Infusion to be administered per Vivo protocols.

INTRALIPID THERAPY ADMINISTRATION (\$400/treatment)

****Medication to be obtained by patient****

LABORATORY ORDERS

CBC at each dose every _____
 CMP at each dose every _____
 CRP at each dose every _____
OTHER _____

Intralipids 20% 100 ml in 0.9% Sodium Chloride (500 ml)

Intralipids 20% 250 ml in 0.9% Sodium Chloride (750 ml)

PREMEDICATIONS

acetaminophen (Tylenol) 500 mg 650 mg 1000 mg PO
cetirizine (Zyrtec) 10mg PO
loratadine (Claritin) 10mg PO
diphenhydramine (Benadryl) 25 mg 50 mg PO IV
methylprednisolone (Solu-Medrol) 40mg 125mg IV
hydrocortisone (Solu-Cortef) 100mg IV
Other: _____
Dose: _____ Route: _____

REQUIRED DOCUMENTATION

Patient Demographics

Progress Notes Supporting Dx

Medication List and H&P

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted.**

Provider Name (Print)

Provider Signature

Date

Fax Numbers

Virginia: 804-500-5941	Nevada: 702-489-5744	Massachusetts: 800-540-1852
Colorado: 303-418-4679	New Jersey: 609-955-3711	Pennsylvania: 215-399-9244
Florida: 904-930-4211	Ohio: 216-400-0674	New York: 800-540-1852
Texas: 469-340-0044	Oklahoma: 918-770-4421	Connecticut: 203-724-4838

Have a Question? (720) 902-4111

Email Referrals To: referrals@vivoinfusion.com

Email Specialty Referrals to:
info@specialtyinfusion.com

Revision Date 5/2024