

Orbactiv[®] & Kimyrsa[™] Referral Form

Please complete the following and send with demographics sheet,
H&P, progress notes, medication list, and lab results to:
p: 844.575.1515 | f: 844.797.5050 | e: specialtyreferrals@soleohealth.com

REFERRAL PROCESS	
1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Name:	Physician's Name:
Address:	ARNP/PA:
City: State: Zip:	License #:
Home Phone: Mobile:	NPI #:
Caregiver Name:	DEA #: PA #:
Caregiver Relationship:	Hospital:
Caregiver Phone:	Office Contact:
Discharge Date: Start of Care Date:	Address:
Patient signed a DNR? <input type="checkbox"/> Yes <input type="checkbox"/> No	City: State: Zip:
Email:	Phone:
DOB: Social Security #:	Fax:
Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Nonbinary	Nursing Agency:
Height: Weight:	Nursing Agency Phone:
Allergies:	
3. DIAGNOSIS Please complete with ICD code and description.	
4. INSURANCE INFORMATION Please submit copies of the front and back of primary and secondary insurance cards with this referral.	
5. ORBACTIV or KIMYRSA ADMINISTRATION ORDERS* Carefully follow dose preparation and administration guidelines per manufacturer <input type="checkbox"/> Orbactiv 1200 mg/1000 ML D5WIV over 3 hours x 1 dose, administered by a registered nurse <input type="checkbox"/> Orbactiv _____ <input type="checkbox"/> Kimyrsa 1200 mg/250 ML NS or D5W IV over 1-hour x 1 dose, administered by a registered nurse <input type="checkbox"/> Kimyrsa _____ * Note: A clinical pharmacist from Soleo Health is available for consultation at the phone number at the top of this form. FLUSH ORDERS PIV/midline/PICC: Flush before, after each infusion, and as needed with 3-20 mL D5W (Orbactiv) or NS (Kimyrsa), followed by Heparin 10 unit/mL, 2-5 mL if indicated Port: Flush before, after each infusion, and as needed with 5-20 mL D5W (Orbactiv) or NS (Kimyrsa), followed by Heparin 100 unit/mL 5 mL. ANAPHYLAXIS ORDERS Adults: For mild reaction-administer diphenhydramine 50mg IVP/PO x 1. For severe reactions-administer epinephrine 0.3mg SubQ/IM x 1. May repeat x1 if needed. Contact 911 and monitor vital signs. <input type="checkbox"/> Other: _____ Labs: _____	
6. NURSING ORDERS: RN to assess, administer, and/or instruct patient/caregiver on medication, administration, vascular access device, disease process, signs or symptoms of adverse effects or complications of therapy. RN to establish, maintain and discontinue vascular access device. RN to draw labs as ordered via vascular access device or venipuncture.	
7. <input type="checkbox"/> Dispense as written PHYSICIAN'S SIGNATURE (required): _____ Date: _____	