Dorset HealthCare
University NHS Foundation Trust

Referral for Community IV Therapy Service

IV Antibiotics

Please attach patient sticker here or record:

Name:……..
Address:……Tel:……
NHS No:
HOSP No:
D.O.B:
GP Name…… Address……...Tel:

Diagnosis	
Past Medical History	
Resuscitation Status	(If DNAR attach form)
Current medications	(attach a separate sheet if available)

Is the patient aware of the reason for the IV Antibiotics?

Yes ☐ No ☐

Has a verbal explanation of procedure, risks and benefits been given?

Yes ☐ No ☐

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REQUEST FORM

Please attach patient sticker here or record:

Name:……..
Address:……Tel:……
NHS No:
HOSP No:
D.O.B:
GP Name…… Address……..Tel:

Clinic Location	
Reason for Medication	
Clinical details including cause of infection	
Previous antibiotic reaction if any?	
Last blood results	**WCC** **CRP**

Prescription form

Date	
Medication	**Dilutant** Flush Hepsal 5mls Saline 0.9% 5mls
How often/route	
Signature	

Please fax to ……The patient will be contacted within 2hrs by the community IV hub to arrange the therapy.

This form acts as a patient-specific-directive for administration of treatment. It is the referrers responsibility to ensure appropriate treatment is requested.

Referrer Name	Signature	Date