

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M F Ht: _____ Wt: _____ lbs kg
 Primary Language: _____ Allergies: _____
 Patient Preferred Location: _____

<ICD 10 CODE REQUIRED>

DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code

ICD 10 Code: _____
 Description: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.
LAB RESULTS: Please include lab results to support diagnosis.

PRESCRIPTION

Pre-Medications

Lab Orders

Acetaminophen: 650 mg PO
 Cetirizine: 10 mg PO
 Diphenhydramine: 25 mg PO
 Diphenhydramine: 25 mg IV
 Famotidine: 20 mg PO
 Methylprednisolone: 125 mg SIVP
 Ondansetron: 4 mg ODT
 Ondansetron: 4 mg IVP
 Other: _____

Lab: _____ Frequency: _____
 Lab: _____ Frequency: _____
 Lab: _____ Frequency: _____

Medication to Order: _____
 Dose: _____
 Route: _____
 Frequency: _____
 Duration: _____

Post Treatment Observation: The patient is observed for 30-60 minutes depending on therapy following the first administration.

Adverse Reactions: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.

Comments:

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____
 Date: _____ NPI #: _____ Specialty: _____
 Supervising Physician: _____ (If Applicable)
 Address: _____ City: _____ State: _____ Zip: _____
 Contact Name: _____ Phone: _____ Fax: _____ Email: _____