Infusion Order Form

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

<ICD 10 CODE REQUIRED>

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

☐ 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 Orders

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

Medication to Order: _____

Dose: _____

Route: _____

Frequency: _____

Duration: _____

Is the patient on any other disease modifying therapy? ☐ Yes ☐ No
If yes, please note therapy and last dose: _____

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: _____