

## Patient Information

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

## Diagnosis

### ICD 10 Code

ICD 10 Code: \_\_\_\_\_  
Description: \_\_\_\_\_

## Medication Order

### 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: \_\_\_\_\_

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

Comments: \_\_\_\_\_

## Required Clinical Documentation

**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.

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

**LAB RESULTS:** Please include lab results to support diagnosis.

**Medix Infusion will collect all necessary labs if not included in referral documents.**

## Referring Provider Information

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