Medication 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

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

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.

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

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

Referring Provider Information

To Prescriber: By signing this form and utilizing our services, you are also authorizing Medix Infusion to serve as your prior authorization designated agent in deaing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: _____ Date: _____

Prescriber Name: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____