

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



Office: 212-803-3339 Fax : 646-768-8600

Date: _____

INFUSION/INJECTION orders

| PATIENT INFORMATION | | |
|--|---------------------|--|
| Name: | DOB: | SEX: M <input type="checkbox"/> F <input type="checkbox"/> |
| ICD-10 code (required): | ICD-10 description: | |
| <input type="checkbox"/> NKDA Allergies: | Weight lbs/kg: | |

| REFERRAL STATUS | |
|---|--|
| <input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> Discontinuation Order | |

| PHYSICIAN INFORMATION | |
|----------------------------|--|
| Referral Coordinator Name: | Referral Coordinator Email: |
| Ordering Provider: | Provider NPI: |
| Referring Practice Name: | Phone: _____ Fax: _____ |
| Practice Address: | City: _____ State: _____ Zip Code: _____ |

DIAGNOSIS *Please provide ICD-10 code*

_____ (other)
(ICD-10) (description)

_____ (other)
(ICD-10) (description)

PRE-MEDICATION

Tylenol 1000mg PO Solu-Medrol 125mg IVP
 Diphenhydramine 25mg PO Solu-Cortef 100mg IVP
 Cetirizine 10mg PO Diphenhydramine 25mg IVP

_____ (other) _____ (other)

INFUSION/ INJECTION ORDERS

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____