

Chicago Illinois  
4711 Golf Road  
Suite 900  
Skokie, IL 60076



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*

\_\_\_\_\_ (ICD-10) \_\_\_\_\_ (description) (other)

\_\_\_\_\_ (ICD-10) \_\_\_\_\_ (description) (other)

**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 \_\_\_\_\_