

Vermont
28 Park Ave
Suite #1A
Williston, VT 05495



Date: _____

INFUSION/INJECTION orders

PATIENT INFORMATION		
Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐ NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS	
☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ 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	INFUSION/ INJECTION ORDERS
☐ _____ (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 _____ (other) _____ (other)	

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____