INFUSION/INJECTION ORDERS

PATIENT INFORMATION

Patient Name:			DOB:
Date of last treatment: ☐ N/A (new start)	Height: ☐ IN ☐ CM	Weight: ☐ LBS ☐ KG	Sex: ☐ M ☐ F
Diagnosis: (include ICD-10 codes)			

Please check to indicate the following ***required*** documents have been attached:

- ☐ Patient Demographics
- ☐ Copies of insurance card (front/back)
- ☐ Records of previously tried/failed treatments
- ☐ Current medication/allergy list
- ☐ Notes supporting diagnosis & medical necessity of ordered treatment (office notes, lab results, imaging reports)
- ☐ Other:

ORDERS

Patient Monitoring:

- ☐ Hold treatment and notify provider for: _____
- ☐ Monitor for _____ minutes after treatment prior to discharge
- ☐ Other:

Lab Orders:
(include frequency)

Pre-medications:

Infusion Reaction/Anaphylaxis Orders:

☐ Per facility protocol

MEDICATION (drug and dose)	INSTRUCTIONS (route, infusion rate(s), diluent type/volume)

Additional Orders:

Frequency:

☐ Once ☐ Every _____ days / weeks / months (circle one) ☐ Other: _____

REFERRING PROVIDER INFORMATION

Practice Name:	Phone Number:	
Office Contact:	Fax Number for treatment notes:	
Provider Name: (please print)		Date:
Provider Signature:		Order valid for: ☐ one (1) Year ☐ other: _____

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NATIONAL INFUSION CENTER ASSOCIATION