

Outpatient Infusion Center Osteoarthritis Order

Please fax form to: 580-585-5472

Patient Information						
Patient Name:		DOB:			Phone:	Gender: M F
Patient Address:		Email:		Insurance:		
Additional Information Needed						
Fax front/back of insuran	Fax clinic	al/progres	ss notes	Fax lab	s	
Fax patient demographics		Fax current medication list			Fax TB and Hep B results	
Diagnosis and Clinical Information						
Diagnosis (ICD-10): M17.0 Bilateral Primary (M17.4 Other bilateral Se M17.11 Unilateral Primar M17.5 Other Unilateral S M17.2 Bilateral Post-Tra M17.9 OA of Knee, Unsp	condary OA of Knee ry OA, Right Knee lecondary OA of Kne umatic OA of Knee pecified					
Clinical Information:						
New Therapy Induction Patient Weight: Allergies:		Therapy Cl Patient Hei	nange ight:	in/_	Therap cm	by Continuation
Therapies Tried and Failed:						
Lab Orders						Lab Orders to be done by
CBC w/o diff CMP Other:	ESR CRP	HBsAg HB	BsAB H	IBcAB	Quantiferon Gold	Infusion Services Referring Provider
Prescription Information						
Durolane Gelsyn-3 Supartz FX Other	Directions: Dose: 16.8mg/2 Directions: Dose: 25mg/2.5	Right Knee PmL Prefilled Syl Right Knee ImL Prefilled Syl Right Knee	Left Kr ringe Left Kr ringe Left Kr	nee Frequ Pree Frequ nee	iency: Intra-articularl Both Knees C iency: Intra-articularl Both Knees C	y one time other Joint: y every week for 3 weeks other Joint: y every week for 5 weeks other Joint: requency:
Misc Orders						
			Flusi 10 H	hes 0mL NS I leparin 50 0ml NS B	Flush Syringe PRN 00units/5mL Flush S	
Standing Orders for Adverse Reaction						
Stop infusion and initiate NS bolus				-	1mL IM, IV or SQ f	or anaphylaxis
Notify Supervising physic				5L nasal cannula		
Solu-Cortef 100mg SIVP		Albuterol 2.5mg inhaled PRN to chest tightness Other:			o chest tightness	
Prescriber Information						
Physician Name:						
Contact #:						
		City/State/Zip:				
NPI#:	DEA#:	S	State Lice	nse #:		
Physician's Signature			D	ate		Time



08/2021