



Outpatient Infusion Center
Misc Medication 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 insurance card Fax clinical/progress notes Fax labs
 Fax patient demographics Fax current medication list Fax TB and Hap B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

- DX: _____
 DX: _____
 DX: _____

Clinical Information:

- New Therapy Induction Therapy Change Therapy Continuation
 Patient Weight: _____ lbs/ _____ kg Patient Height: _____ in/ _____ cm
 Allergies: _____
 Therapies Tried and Failed: _____
 TB Test: Date: _____ Results: _____ Hep B Test: Date: _____ Results: _____
 Does the patient have venous access? Yes or No If yes, What type? _____
If no, Initiate IV access

Lab Orders

- CBC w/out diff CMP ESR CRP
 Other: _____

Lab Orders to be done by

- Infusion Services
 Referring Provider

Prescription Information

- Medication: _____ Dose: _____ Frequency: _____ Rate: _____
 Medication: _____ Dose: _____ Frequency: _____ Rate: _____
 Medication: _____ Dose: _____ Frequency: _____ Rate: _____

Misc Orders

- _____ PICC/ Midline/ CAD dressing to be changed every 7 days.

 Flushes
 10mL NS Flush Syringe PRN
 Heparin 500units/5mL Flush Syringe PRN
 50ml NS Bag PRN
 250ml NS Bag PRN

Standing Orders for Adverse Reactions

- Stop infusion and initiate NS bolus Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis
 Notify Supervising physician and ordering provider Oxygen 2-5L nasal cannula
 Solu-Cortef 100mg SUP signs of adverse reaction Albuterol 2.5mg inhaled PRN for chest tightness
 Benadryl 25mg SUP for hives or bronchial inflammation Other: _____

Prescriber Information

Physician Name: _____ Office Contact Name: _____
Contact #: _____ Fax Number: _____
Address: _____ City/State/Zip: _____
NPI#: _____ DEA#: _____ State License #: _____

Physician's Signature

Date

Time

