better INFUSIONS

255 TOWN SQUARE, WHEATON, IL, 60189

# Infusion or injection order form

**Date:** ______________

## 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*

☐ ________ ______________________________ (other)
*(ICD-10)* (description)

☐ ________ ______________________________ (other)
*(ICD-10)* (description)

### PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ______________________ *(other)*
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ______________________ *(other)*

PRE-INFUSION LABS

### INFUSION/ INJECTION ORDERS

REQUIRED DOCUMENTS:

_____ Patient Demographics
_____ Insurance Card/Information
_____ Clinical/Progress Notes supporting DX
_____ Current Medication List and H&P

### NOTES/ADDITIONAL COMMENTS:

## ORDERING PROVIDER

Signature **X** ________________________________ Date ____________

Provider ______________________ Phone __________ Fax ____________