SPECIALTY INFUSION CENTERS

GENERAL ORDER FORM

FAX TO: 800-540-1852

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M / F

Ht: _____ WT: _____ lbs / kg Primary Language: _____ Allergies: _____

Patient Preferred Location: ☐ Staten Island ☐ West Harrison ☐ Manhattan ☐ New Paltz ☐ Bronx ☐ Syosset ☐ Port Jefferson ☐ Millburn ☐ Brooklyn Heights ☐ Paramus

DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE)

DX Code: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.
NOTE: Include all pertinent labs to support diagnosis.

PRESCRIPTION

Pre-Medications

☐ Tylenol 650mg PO ☐ Benadryl 25mg IVP ☐ Pepcid 20mg IVP
☐ Zyrtec 10mg PO ☐ Benadryl 50mg PO ☐ Solu-medrol 125mg IVP
☐ Claritin 10mg PO ☐ Benadryl 50mg IVP ☐ Solu-medrol 250mg IVP
☐ Benadryl 25mg PO ☐ Pepcid 20mg PO ☐ Solu-medrol 500mg IVP

Pre Labs:

☐ CBC ☐ Iron Panel
☐ CMP ☐ Vitamin D
☐ CRP ☐ Other _____
☐ ESR

Other: _____

Medication Name _____ Dose _____ mg/g

Frequency _____

_____

_____

_____

In the event of an adverse reaction at a Specialty Infusion center, the adverse reaction protocol will be utilized.

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Supervising Provider (if applicable) _____

Date: _____ NPI#: _____ Specialty: _____

Practice Name: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____