

**Infusion Center
General Order Form**

**To schedule an appointment, please call
303-603-3553 | fax 303-269-4759**

Patient Information

Patient Name _____

DOB _____ SSN _____

Home Phone _____ Other Phone _____

Insurance _____ Auth # (if needed) _____

Date/Time (must include) _____

RX _____ Signature _____

Diagnosis _____ ICD-10 _____

Labs: BMP CBC PT/INR Vancomycin Level Other

Infusions: Antibiotics Solumedrol Iron Infusions Boniva Remicade
 IVIG Fluids Phlebotomy (need parameters)
 Reclast (note: all patients receiving Reclast must have a SCr, Mag, Phos, and Ca result less than 60 days old or labs will be drawn per protocol on day of infusion. CrCl < 35 ml/min is contraindication for infusion)

Injections: Neulasta Epogen Arixtra Xolair Prolia

Blood Products/IVIG/Chemotherapy: please contact the infusion center for specific order set and treatment ability.

Procedures: Central Line Catherter Care PICC/Line Insertion Midline Insertion Other

Special Instructions: _____

Pre Authorizations

Pre-Auth Assistance: for assistance, please fax the following information:
 Clinical Notes Insurance Card (clean copy) Patient Demographics

Results

STAT Read & Call Hold Patient & Call Results Fax Results Only

Physician Information (must be completed)

Physician Name _____

Phone _____ Fax _____

Physician Signature _____ Date _____

Parker Adventist Hospital

