

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____
 ADDRESS: _____ CITY, STATE, ZIP: _____
 DATE OF BIRTH: _____ EMAIL: _____
 ALLERGIES: SEE LIST NKDA WEIGHT: LB OR KG

REQUIRED DOCUMENTATION

1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Most Recent Labs 5. Medication List

PRIMARY DIAGNOSIS

ICD-10 Code: _____

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

Provider Prescribed: _____

PRIMARY MEDICATION ORDER

Please include MEDICATION, DOSE, ROUTE, FREQUENCY, DURATION, and any additional administration instructions:

FIRST DOSE?: Yes No Refill x12 months unless otherwise noted.

LINE USE/CARE ORDERS

Start PIV/ACCESS CVC Flush device per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
 Other Flush Orders: Please send other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

Administer acute infusion and anaphylaxis medications per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
 Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____
 OFFICE CONTACT: _____ FAX: _____
 ADDRESS: _____ EMAIL: _____
 CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

X

PROVIDER SIGNATURE _____ DATE _____