# Infusion/Injection Orders

## Patient Information

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>DOB:</th>
</tr>
</thead>
</table>

Date of last treatment:  
☐ N/A (new start)  
☐ N/A

Height:  
☐ IN  
☐ CM

Weight:  
☐ LBS  
☐ KG

Sex:  
☐ M  
☐ F

Diagnosis:  
(include ICD-10 codes)

Please check to indicate the following *required* documents have been attached:

- ☐ Patient Demographics
- ☐ Copies of insurance card (front/back)
- ☐ Records of previously tried/failed treatments
- ☐ Current medication/allergy list
- ☐ Notes supporting diagnosis & medical necessity of ordered treatment (office notes, lab results, imaging reports)
- ☐ Other:

## Orders

### Patient Monitoring:

- ☐ Hold treatment and notify provider for: ________________________________
- ☐ Monitor for _________ minutes after treatment prior to discharge
- ☐ Other:

### Lab Orders:

(include frequency)

### Pre-medications:

### Infusion Reaction/Anaphylaxis Orders:

☐ Per facility protocol

## Medication

<table>
<thead>
<tr>
<th>Medication (drug and dose)</th>
<th>Instructions (route, infusion rate(s), diluent type/volume)</th>
</tr>
</thead>
</table>

## Additional Orders:

### Frequency:

- ☐ Once
- ☐ Every ____________ days / weeks / months (circle one)
- ☐ Other: ______________________

## Referring Provider Information

<table>
<thead>
<tr>
<th>Practice Name:</th>
<th>Phone Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Contact:</td>
<td>Fax Number for treatment notes:</td>
</tr>
</tbody>
</table>

Provider Name:  
(please print)

Provider Signature:  
Date:

Order valid for:

- ☐ one (1) Year
- ☐ other: ____________________

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Revised Aug 2022