INTRAMED Plus
infusion services

MISCELLANEOUS

INFUSION & MEDICAL CENTER

1. _____ _____ _____
Patient Name **DOB** **Patient Phone/Cell #**

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please indicate primary diagnosis and complete ICD10 Code):

Primary Diagnosis_____ ICD-10 Code: _____

Allergies:_____(or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

• Clinical MD Notes & labs supporting primary diagnosis

Patient
Weight: _____ lbs.
Height:_____ in.

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4. Drug Order:

RX:_____ _____ Doses Authorized

Administration Instructions:

_____

_____

Pre-Medication Orders (check the requested orders):

❑ Common Pre-Medication Orders:

❑ Diphenhydramine 25 mg PO ❑ Diphenhydramine 50 mg IV ❑ Cetirizine 10 mg PO ❑ Loratadine 10 mg PO

❑ Acetaminophen 650 mg PO ❑ Solumedrol _____ mg IV ❑ Normal Saline (0.9%) _____ mg IV

❑ Other: _____

❑ NONE

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus
to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name:_____Contact Phone #: _____

FAX ALL INFORMATION **CENTRAL FAX 803.999.1754**	**INFUSION CENTER LOCATIONS** **COLUMBIA CHARLESTON GREENVILLE** **CENTRAL INTAKE PHONE 803.999.1760**