

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.

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 ALTERNATE FAX 803.999.1887	INFUSION CENTER LOCATIONS COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 803.999.1960
--	---