COOKEVILLE REGIONAL MEDICAL CENTER
OUTPATIENT INFUSION CENTER

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www.crmchealth.org

INFUSION CENTER ORDER FORM

Date:

Patient Name:

Date of Birth:

SSN:

❑ Ambulatory ❑ Wheelchair ❑ Bed

Allergies:

Weight: _____ lb _____ kg Height: _____

ICD-10 Code:

THERAPY STATUS

❑ New Start

❑ Continuing Therapy Last Dose: _____

PROVIDER INFORMATION

Ordering Provider: _____

Provider NPI: _____

Provider Phone: _____

Provider Fax: _____

Provider Address: _____

Tax ID Number: _____

MEDICATIONS PREVIOUSLY TRIED/FAILED

MEDICATION ORDER

	DRUG	DOSE	FREQ
Initial			
Maintenance			
Other			

Refills x one year from date of signature unless indicated below.

_____ Refills

PREMEDICATIONS - ORAL

❑ Acetaminophen: ___325mg ___500mg ___650mg
❑ Loratadine: 10 mg
❑ Diphenhydramine: ___25mg ___50mg
❑ Famotidine: ___20mg ___40mg
❑ Ibuprofen: ___200mg ___400mg ___600mg
❑ Ondansetron: ___4mg ___8mg
❑ Other: _____

PREMEDICATIONS - IV

❑ Dexamethasone: ___4mg ___8mg
❑ Diphenhydramine: ___25mg ___50mg
❑ Famotidine: ___20mg ___40mg
❑ Methylprednisolone: 125 mg
❑ Hydrocortisone: 100 mg
❑ Ondansetron: ___4mg ___8mg
❑ Other: _____

LAB ORDERS

Surveillance lab ordering and monitoring is the responsibility of the prescriber

OTHER REQUIRED INFORMATION

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Dispense as Written:

_____ _____
PRESCRIBER NAME DATE

Substitution Allowed:

_____ _____
PRESCRIBER NAME DATE