



option care health®

## INFUSION CLINIC PRESCRIBER ORDER FORM: ARIZONA

Clinical Hours of Operation Vary by Location				800.395.9246		866.413.6259	
REFERRAL STATUS			ARIZONA LOCATION				
<input type="checkbox"/> New Referral <input type="checkbox"/> Order Renewal			<input type="checkbox"/> Scottsdale				
PATIENT INFORMATION							
PATIENT NAME:			DOB:		GENDER:		
WEIGHT: <input type="checkbox"/> LBS <input type="checkbox"/> KG			PHONE NUMBER:				
ALLERGIES:			EMAIL:				
Please check that the following are included:		<input type="checkbox"/> Patient demographics and insurance attached		<input type="checkbox"/> Clinical/Progress Notes, H&P, Labs, Tests, supporting DX Attached			
		<input type="checkbox"/> Current Medication List:					
DIAGNOSIS							
ICD-10 CODE:		OTHER:		DATE OF LAST INFUSION/INJECTION:			
PHYSICIAN INFORMATION							
PHYSICIAN NAME:			PHONE NUMBER:				
PRACTICE NAME:			FAX NUMBER:				
OFFICE CONTACT:							
MEDICATION ORDER							
MEDICATION:		DOSING:		FREQUENCY:		NOTES/COMMENTS:	
PHYSICIAN SIGNATURE _____					DATE (Order is Valid for One Year) _____		
LAB ORDERS							
<input type="checkbox"/> CMP	<input type="checkbox"/> CBC	<input type="checkbox"/> CRP	<input type="checkbox"/> ESR	<input type="checkbox"/> Other _____			
<input type="checkbox"/> Labs to be Drawn by Infusion Center		Frequency _____		Standing Order? <input type="checkbox"/> Yes <input type="checkbox"/> No			
TYPES OF ACCESS							
<input type="checkbox"/> Peripheral	<input type="checkbox"/> PICC	<input type="checkbox"/> Midline	<input type="checkbox"/> Port	<input type="checkbox"/> Subcutaneous	<input type="checkbox"/> Intramuscular		