

INFUSION CLINIC PRESCRIBER ORDER FORM: UTAH

Clinical Hours of Operation Vary by Location Intake team available Mon-Fri 7:30am-6pm	801.577.7055	888.717.7578
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REFERRAL STATUS	UTAH LOCATION
<input type="checkbox"/> New Referral <input type="checkbox"/> Order Renewal	<input type="checkbox"/> American Fork <input type="checkbox"/> Layton <input type="checkbox"/> Murray <input type="checkbox"/> St. George <input type="checkbox"/> Tooele

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:
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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) _____
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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
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