PRESCRIPTION ORDER FORM

Drug Name:_____

Suite Life
Infusing health and wellness into your life.
215 Pleasant Street, 5th Floor, Fall River, MA 02721
Phone: (508) 567-5666 | Fax: (508) 567-5614

PATIENT DEMOGRAPHICS

Name:	Allergies:
Date of Birth:	Phone Number:
Sex:	Street Address:
Height:	City, State, Zip:
Weight:	Insurance ID:

REQUIRED DOCUMENTATION

• Insurance Card • H & P • Patient Demographics • Labs: CBC w/ Diff, LFTs, & Lipid Panel • Medication List

• TB Test - Date: _____ Results: _____

PRIMARY DIAGNOSIS

☐ _____ ☐ _____

☐ _____ ☐ _____

☐ _____ ☐ **Other:** _____

PRE-MEDICATIONS (15 - 20 MINS BEFORE INFUSION)

☐ Diphenhydramine 25mg PO or IVP & 50mg PO or IVP ☐ Solu-Medrol 40mg IVP ☐ Solu-Cortef 125mg IVP

☐ Cetrizine 10mg PO ☐ Pepcid 20mg PO or IVP ☐ Tylenol 650mg

☐ **Other:** _____ ☐ **Other:** _____

LAB ORDERS

☐ CBC w/ diff & ANC ☐ LFT's at month 2 then every 3 months after

Frequency: _____ ☐ **Other:** _____

ACCESS ORDERS

☐ Start PIV/access CVC ☐ Flush per Suite Life Medical Policy and Protocol

☐ **Other:** _____

PRESCRIPTION ORDER

☐ _____ ☐ _____

☐ _____ ☐ _____

☐ _____ ☐ _____

☐ _____ ☐ _____

Note: _____

First Dose: ◯ Yes ◯ No ☐ Follow Suite Life Medical policy and procedure for all infusion/medication reactions

ORDERING PROVIDER

Provider Name: _____ NPI Number: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____