InfusaCare Medfuse

Infusion/Injection Order

Patient Name:			DOB:	□ Male	□ Female
Diagnosis (please provide	e ICD10 code):				
□ Other:					
□ NKDA	□ Allergies:				
□ New Therapy Order	v Therapy Order □ Continuation of Therapy		Date of last dose:		
Ordering Provider Name:					
Provider NPI:		Phone:		Fax:	
Practice Address:		City:		State:	Zip Code:
Pre-Medication			Required Documentation	:	
□ Acetaminophenmg by □ PO			□ Patient Demographics		
□ Cetirizinemg by □ PO			☐ Patient Insurance (med and pharm card copies, front and back)		
□ Diphenhydraminemg by □ PO/ □ IVP			☐ Progress Notes/Labs supporting diagnosis		
□ Solu-Medrolmg by □ PO/ □ IVP			□ Other:		
□ Solu-Cortefmg	by □ PO/ □ IVP		-		
□ Other:					
Patient height and weigh	nt:				
Patient Height (cm):			Patient Weight (kg):		
Additional Instructions/	Notes:				
Ordering Provider:					
Signature:			Date:		
Provider:					
Best Contact Person in Office:				Tux	
Locations: Skokie, IL: 4711 Golf Rd, St Libertyville, IL: 1900 Hollist	e 900. P: 847-324-6800. F: 224-251- er Dr, Ste 210. P: 847-324-6800. F: 2 eway, Ste 111. P: 346-738-9600. F: 3	-7141 224-251-71	41		