

Infusion/Injection Order

Patient Name: _____ DOB: _____ ☐ Male ☐ Female

Diagnosis (please provide ICD10 code): _____

☐ Other: _____

☐ NKDA ☐ Allergies: _____

☐ New Therapy Order ☐ Continuation of Therapy Date of last dose: _____

Ordering Provider Name: _____

Provider NPI: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Pre-Medication

- ☐ Acetaminophen _____mg by ☐ PO
- ☐ Cetirizine _____mg by ☐ PO
- ☐ Diphenhydramine _____mg by ☐ PO/ ☐ IVP
- ☐ Solu-Medrol _____mg by ☐ PO/ ☐ IVP
- ☐ Solu-Cortef _____mg by ☐ PO/ ☐ IVP
- ☐ Other: _____

Required Documentation:

- ☐ Patient Demographics
- ☐ Patient Insurance (med and pharm card copies, front and back)
- ☐ Progress Notes/Labs supporting diagnosis
- ☐ Other: _____

Patient height and weight:

Patient Height (cm): _____ Patient Weight (kg): _____

Infusion/Injection Medication Order:

Please include name of the medication, dosage, mode of administration, frequency, and other pertinent dosage information:

Additional Instructions/Notes:

Patient IV Access

- ☐ PIV
- ☐ Use patient's SL/DL PICC, flush per protocol
- ☐ Access/deaccess patient's Port, flush per protocol
- *Imaging results of proper placement required for PICC/Port

Ordering Provider:

Signature: _____

Date: _____

Provider: _____

Phone: _____ Fax: _____

Best Contact Person in Office: _____

Phone: _____

Locations:

- ☐ Skokie, IL: 4711 Golf Rd, Ste 900. P: 847-324-6800. F: 224-251-7141
- ☐ Libertyville, IL: 1900 Hollister Dr, Ste 210. P: 847-324-6800. F: 224-251-7141
- ☐ Orland Park, IL: 16612 107th Ct, Ste B. P: 847-324-6800. F: 224-251-7141
- ☐ Houston, TX: 8303 SW Freeway, Ste 111. P: 346-738-9600. F: 346-613-8400