Wasatch INFUSION

FAX: 888.717.7578
CONTACT: 801.577.7055
OPEN: 365 days a year 8am-8pm
Murray, Tooele

ORDER FORM

REFERRAL STATUS

☐ New Referral ☐ Order Renewal ☐ Restart

PATIENT INFORMATION

PATIENT NAME:	DOB: SEX: ☐ M: ☐ F:
WEIGHT: ☐ LBS ☐ KG	PHONE #:
ALLERGIES:	EMAIL:
Please check that the following are included: ☐ Patient demographics and insurance attached	☐ Clinical/Progress Notes, H&P, Labs, Tests, supporting DX Attached
☐ Current Medication List	

DIAGNOSIS

ICD-10 CODE:	Date of last infusion/injection:

PHYSICIAN INFORMATION

Physician Name:	Email (if you would like treatment confirmations):
Practice Name:	
Office Contact:	Phone: Fax:

MEDICATION ORDERS

ORDERS: Medication:	Dosing:	Frequency:	Notes/Comments

Physician Signature _____ Date (Order is Valid for One Year) _____

STANDING LAB ORDERS

☐ Labs to be Drawn by Infusion Center Frequency: _____ Every Infusion:

☐ CMP ☐ CBC ☐ CRP ☐ ESRP ☐ HFR

☐ Other (please specify)

TYPE OF ACCESS

☐ Peripheral ☐ PICC ☐ Midline ☐ Port