Wasatch INFUSION is NOW option care health®

IMMUNE DEFICIENCY ORDER FORM

Open 365 Days A Year • 8am - 8pm • By Appointment 801.577.7055 888.717.7578

REFERRAL STATUS	LOCATION
☐ New Referral ☐ Order Renewal	☐ Murray ☐ Tooele ☐ Layton ☐ St. George

PATIENT INFORMATION

PATIENT NAME:	DOB:	SEX: ☐ M ☐ F
WEIGHT: ☐ LBS ☐ KG	PHONE NUMBER:	
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: OTHER:	DATE OF LAST INFUSION/INJECTION:

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) _____

LAB ORDERS

☐ CMP	☐ CBC	☐ CRP	☐ ESR	☐ Other _____
☐ Labs to be Drawn by Infusion Center	Frequency _____		Standing Order? ☐ Yes ☐ No	

TYPES OF ACCESS

☐ Peripheral	☐ PICC	☐ Midline	☐ Port	☐ Subcu	☐ I/M