Washington MEDICAL CENTER

FAX: 636-330-2363 Phone: 636-202-9400

IMMUNE DEFICIENCY ORDER FORM

REFERRAL STATUS

☐ NEW REFERRAL ☐ ORDER RENEWAL

PATIENT INFORMATION

PATIENT NAME:	DOB:	SEX: ☐ M ☐ F
WEIGHT: ☐ LBS ☐ KG	PHONE NUMBER:	
ALLERGIES:	EMAIL: dddd	

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: ddd

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