Washington MEDICAL CENTER

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

# SPECIALTY MEDICATIONS ORDER FORM

## REFERRAL STATUS

NEW REFERRAL ☐ ORDER RENEWAL ☐

## 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