Washington MEDICAL CENTER

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

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:
Remicade	☐ 5mg/kg ☐ 10mg/kg	☐ Initial: Day 1, Week 2, Week 6	
	☐ Other	☐ Maintenance: Every 8 weeks	
		☐ Other	

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