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:
Tepezza	**1st Infusion: 10mg/kg** **2nd Infusion: 20mg/kg** **3rd – 8th Infusion: 20mg/kg**	Once every 3 weeks for a total of 8 insusions	

PHYSICIAN SIGNATURE ______________________ DATE (Order is Valid for One Year) ____________

LAB ORDERS

☐ CMP ☐ CBC ☐ FERRITIN ☐ IRON tBIC ☐ OTHER ____________

☐ Labs to be Drawn by Infusion Center Frequency ____________ Standing Order? Yes No

TYPES OF ACCESS

☐ Peripheral ☐ PICC ☐ Midli ne ☐ Port ☐ Subcu ☐ I/M