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:	
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