**

***OUTPATIENT INFUSION CLINIC FORM***

**PATIENT INFORMATION**

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Referral\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REFERRAL STATUS**

\_\_\_\_\_ **New Referral \_\_\_\_\_ Dose or Frequency Change \_\_\_\_\_ Order Renewal**

**DIAGNOSIS AND ICD-10 CODE**

**Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICATION ORDERS**

**Please indicate medication, pre-medications, dose, route and frequency:**

**Refills: \_\_\_\_\_ X 6 Months \_\_\_\_\_ X 1 Year \_\_\_\_\_ Doses**

**PRESCRIBER INFORMATION**

Prescriber Name (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescriber Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time\_\_\_\_\_\_\_\_\_\_\_

**REQUIRED DOCUMENTATION**

* This signed order form by the provider
* Clinical/Progress notes supporting primary diagnosis
* Labs and tests supporting primary diagnosis (including CBC & I Iron Panel)
* Patient demographics and insurance
* Prior Authorization # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reference # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAX COMPLETED FORM AND ALL DOCUMENTATION TO:**

***Clay County Hospital Outpatient Infusion Clinic***

***Call 618-844-3062 Fax 618-844-3288***

(Form 801.010)