APPALACHIAN Regional Healthcare System	Patient Name_____ Date of Birth_____ Phone Number_____ Please Fill in or Affix a Patient Label

Infusion Referral Order

(Form must be completed before the patient can be scheduled for the Infusion)

Non-Chemo (WMC IV Infusion Suite)

Phone: ***(828) 262-4412*** **Fax:** ***(828) 268-9046***

Date: Referring Provider: NPI #:

Referring Office: Referring Office Contact Person:

Address:

Telephone #: Fax #:

After Hours/ Weekend Contact:

PATIENT INFORMATION

Patient Full Name: DOB:

Address: City: State: Zip:

Home Phone #: Daytime Phone #:

INSURANCE INFORMATION

Insurance Name/Type:

Group#: ID#: Pre-Authorization # for Reimbursement:

CLINICAL INFORMATION (PLEASE INCLUDE HISTORY & PHYSICAL AND/OR RECENT OFFICE NOTE, AND MEDICATION LIST)

Diagnosis: (ICD-10):

Name of Medication: Specialty Pharmacy:

Route: ☐IV ☐subQ ☐IM ☐PO ☐Other; please specify:

Dose: Frequency: Number of Treatments: Start Date: End Date:

Premedication: (not given unless checked)

☐Tylenol 650mg PO x 1 ☐ Solu-Medrol _____mg IV x 1 ☐_____

☐Benadryl 25mg PO x 1 ☐_____ ☐_____

☐Decadron _____mg IV x 1 ☐_____ ☐_____

☒ Alteplase Flush (CathFlo) Injectable 2 milligram(s) flush once to declot PICC Line/ Port a cath PRN Per WMC Hospital Policy

Labs (please include frequency):

☐ CBC Frequency:_____(required for Procrit/Epogen or Aranesp) ☐ BMP Frequency:_____

☐ Serum Creatinine Frequency:_____(required for Reclast or Zometa) ☐ Other:_____

Additional Orders:

Provider Signature ▸	Date: Time:

Appointment Information **(For APPRHS Staff Only)**

☐Patient aware of appointment ☐Unable to contact patient

Appointment Date: _____ Time: _____ am / pm Provider:_____

Effective Date: 11/14/2016
Revised Date: 05/25/2018
Form Number: 11166